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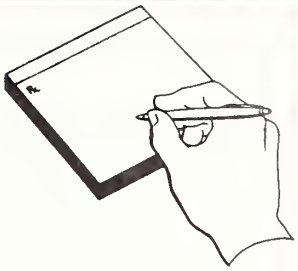

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- Stevens-Johnson syndrome, toxic epidermal necrolysis, and anaphylaxis have been reported rarely. Anaphylaxis may be more common in patients with a history of penicillin allergy.
- Gastrointestinal (mostly diarrhea): 2.5%
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
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The main overlook at Hawk's Nest State Park provides a magnificent view of a section of the New River Gorge on a winter's day—Photo courtesy *Wonderful West Virginia,* Gerald Ratliff, photographer.

Factors Affecting Choice of Entity in Setting Up the Medical Professional Practice

STEVE THOMAS
Kay, Casto, Chaney, Love & Wise, Charleston

As a result of recent changes to the Internal Revenue Code, tax considerations play a relatively minor role among all factors to be considered in deciding whether or not to incorporate a medical professional practice.

As a result of these changes, a sole practitioner is often well advised to conduct business as a proprietor, instead of as a one-person corporation. For many of the same reasons, two or more persons associated in a medical practice may be better off conducting business as a partnership, rather than as a corporation.

One of the oldest of reasons for choosing to incorporate a business is to achieve limited liability. Not surprisingly, financial institutions are reluctant to lend substantial funds to a 'mere' corporation. Thus, as a practical matter, the principals of a medical professional corporation will inevitably be required to personally endorse working capital loans for their corporate medical practice. However, the potential for avoiding personal liability through operation as a corporation still exists in two respects.

First, the medical professional corporation usually will be able to obtain trade credit in the name of the corporation alone. Thus, in the event a practice fails, the corporation may be able to wind down its business by paying its working capital loan (on which its principal is endorsed) to the exclusion of its trade creditors.

The second area where the limited liability available in the corporate form retains value concerns malpractice. Specifically, a medical professional in association with other professionals can shield himself from the malpractice of his or her partners by conducting business as a corporation. Historically, malpractice insurance has been available to offset this need for protection from unlimited liability. However, given rising insurance costs and liberal jury awards in personal injury cases, the value of limited liability through corporate operation should not be ignored.

The main drawbacks associated with doing business as a corporation involve the formalities and complexities attendant to the corporate form. Incorporation requires the filing of Articles of Incorporation with the Secretary of State. Thereafter, the board of directors named in the Articles of Incorporation must meet to adopt bylaws and elect officers. Directors meetings and shareholders meetings must be held at least annually, and shareholders are required by law to pay for the shares of stock to which they subscribe. In short, choosing the corporate form involves paying heed to corporate formalities. Failure to attend to these corporate formalities can lead to attempts by corporate creditors to "pierce the corporate veil" in order to directly sue the corporation's shareholders.

In addition to the investment of time which the principals of a corporation must make in order to attend to corporate formalities, greater legal and accounting fees can usually be expected. The assistance of legal counsel is highly recommended in setting up a corporation and attending to the record of corporate meetings. Also, accounting services will be needed for the corporation, as a separate taxable entity. Finally, formal employment contracts for the corporation's principals and a shareholders agreement governing the disposition of stock, are usually desirable.

Medical professionals choosing to do business in the corporate form must also take measures to insure that all profits are distributed in a tax-deductible manner to avoid corporate taxation. This is because the tax on income of a professional corporation exceeds the top individual income tax rate (assuming the corporation has not made a sub-chapter S election). This objective of distributing all profits in a tax-deductible manner is generally achieved through a bonus system. Again, the design of such a bonus system entails greater accounting, and potentially legal costs. To avoid this problem, make an election to be taxed as an S Corporation. In this case, income (or loss) is taxed directly to the S Corporation shareholders, at their individual rates. Limited liability is thus achieved with treatment similar to a partnership.

In contrast to the corporate form, doing business as a sole proprietor is relatively simple in terms of organization and record keeping. No formal documents are needed for the establishment of a sole proprietorship. Moreover, there is no need for annual meetings or formal employment contracts which are commonplace in corporations.

Doing business as a partnership lies somewhere between the corporate form and the proprietorship in terms of documentation and complexity. Like a proprietorship, no formal document is needed for the establishment of a partnership, although a formal partnership agreement is highly recommended

to avoid potential misunderstandings. The partnership is not a separate taxable entity per se; rather, the various tax attributes (elements of income and expense) of the partnership are allocated to the partners.

In a partnership, each individual is an agent of the partnership and for each of the partners for the purpose of partnership business. Accordingly, the malpractice of a partner may expose all other partners to liability, to the extent of a deficiency in malpractice coverage. The tendency in West Virginia for liberal jury awards thus creates room for concern about this matter.

Tax considerations have largely been eliminated from the factors to be considered in choosing the form of entity for purposes of the medical professional practice. Before TEFRA (the Tax Equity and Fiscal Responsibility Act of 1982), tax-qualified retirement plans of self-employed individuals were subject to significant limitations compared to corresponding plans available to corporations. TEFRA repealed many of the disadvantages attendant to qualified self-employment plans (or "Keough plans"), and/or imposed the same limitations on qualified plans of corporations via the so-called "top heavy" rules. These rules apply to retirement plans under which 60 percent or more of the benefits or contributions inure to the benefit of certain officers and owners known as "key employees."

After TEFRA, only a few relatively minor restrictions apply to qualified plans of proprietorships and partnerships but not to corporations. For instance, a loan between the qualified plan of an unincorporated entity and a self-employed individual is a prohibited transaction. Also, the maximum amount a self-employed individual may deduct is limited to that individual's income after taking into account the qualified plan deduction. This does not hold true for participants in corporate plans. Thus, a corporate plan participant making $120,000 per year with a money purchase pension plan of 25 percent could have contributions made in the amount of $30,000. If the same person were a "self-employed individual," the retirement plan contribution deduction would be limited to $24,000 (25 percent of $96,000, that is, the amount that is left ($120,000 minus $24,000) after taking the retirement plan contribution into account). Aside from this, the attractiveness of tax qualified retirement plans is largely a neutral factor for purposes of choice of entity.

Another significant advantage formerly available to corporations, was the adoption of a tax year different from that of its principals. After the Tax Reform Act of 1986, the opportunity for adopting or retaining a tax year different from a corporation's principals (thereby achieving significant tax savings through deferral of income or acceleration of expenses) is generally foreclosed.

Conclusion

Significant savings may be achieved through operation of the medical professional practice as a proprietorship or a partnership, as opposed to a corporation. The rules governing qualified retirement plans are substantially the same, regardless of the choice of entity. Incorporation entails attention to corporate formalities and greater legal and accounting expenses, whereas so-called "limited liability" may be of limited value. Operation as an S Corporation achieves limited liability, with taxation at individual rates. However, the other complexities and expenses of corporate operation remain tied to S Corporation operation.

What West Virginia Physicians Need to Know About Advance Directives

ALVIN H. MOSS, M.D.
The Center for Health Ethics and Law, West Virginia University Health Sciences Center, Morgantown

In the past, most physicians have been reluctant to discuss with patients the conditions under which they would want to have life-sustaining treatments withheld or withdrawn. Often discussions of topics such as the withholding of cardiopulmonary resuscitation or mechanical ventilation are avoided for fear of discouraging and troubling patients.

However, recent studies have shown that almost all patients would like to talk about these topics with their physicians. These studies also reveal that patients prefer that their physicians start such conversations.

West Virginians now have two types of written advance directives, the Living Will and the Medical Power of Attorney, in which they can state their preferences for future health care should they become unable to participate in health care decisions. This new legislation in West Virginia on advance directives provides physicians with an opportunity to initiate these discussions with their patients.

Impact of Recent Legislation and the Cruzan Case

Three recent events have made it important for West Virginia physicians to be knowledgeable about written advance directives. First, on March 1, 1990, the West Virginia Legislature passed the Medical Power of Attorney Act. The purpose of this act was to ensure that patients' rights to make health care decisions be protected and

communicated. The act established a legal document, the Medical Power of Attorney, which allows a patient to appoint a representative to make health care decisions if he or she is unable to, and to provide specific instructions to that individual's physicians. The Medical Power of Attorney becomes effective only in the event the patient loses decision-making capacity. The representative has the authority to give, withhold or withdraw consent for the health care of the patient.

Physicians who in good faith comply with the directions of a patient's Medical Power of Attorney are protected from civil and criminal liability. Physicians who cannot or will not comply with the patient's directives, are obligated to transfer the patient to another physician. The act also calls for the public to be educated about the right to participate in and direct their health care decisions and the option to complete a Medical Power of Attorney.

Second, on June 25, 1990, the U.S. Supreme Court issued its opinion on the case of Nancy Cruzan, a Missouri woman who for the past seven years has been in a persistent vegetative state as a result of a car accident. The court ruled that individuals have the constitutional right to accept or refuse life-sustaining treatments, and it assumed that artificial nutrition and hydration are among the treatments patients may refuse. Also, it held that states may require a "clear and convincing" evidentiary standard for the withdrawal of life-sustaining treatments in incompetent patients.

Since the Missouri State Supreme Court found that clear and convincing evidence with regard to Nancy Cruzan's wishes was not available, and since the U.S. Supreme Court decision did not reverse the state decision, the hospital and physician treating Nancy Cruzan are obligated to continue her tube feedings. Many commentators have viewed this aspect of the court ruling as unfortunate, since the testimony in the Cruzan case indicated that Nancy had told her friends that she would not wish to continue her life if she could not live at least "halfway normally." She also said that she did not want to live as a "vegetable."

The U.S. Supreme Court decision in the Cruzan case underscores the importance of advance directives. The implication of the Cruzan decision is that people must express their wishes for future health care in a "clear and convincing" manner, in at least some states, to ensure that their wishes will be followed. The West Virginia Medical Power of Attorney provides such clear and convincing evidence.

Third, included in the Omnibus Budget Reconciliation Act, which the Congress passed before it adjourned on October 28, is a provision regarding advance directives. The provision states that as of December 1, 1991, hospitals, skilled nursing facilities, home health agencies, and health maintenance organizations that receive Medicare funding are required to inform patients of their right to make decisions to accept or refuse medical or surgical treatment and the right to execute advance directives. Health care providers will also be required to have written policies respecting advance directives and to document in each patient's chart whether or not the individual has completed an advance directive. Where permitted by state law, institutions may refuse to comply with a patient's advance directives if doing so conflicts with their mission.

The Benefits of Advance Directives

To appreciate the benefits of advance directives, it is first important to understand the difference between a Living Will and the Medical Power of Attorney.

The Living Will is a document with a restricted applicability. For a patient who has completed one, it is effective only when the patient has lost decision-making capacity and has been declared by the attending physician and one other physician to be terminally ill with an incurable injury or illness. In this setting, the Living Will allows the patient only to reject life-prolonging treatments.

In contrast, the Medical Power of Attorney is effective whenever the patient has lost decision-making capacity, and it allows the patient through his/her directions and representative to accept or refuse medical and/or surgical treatments. Since the Medical Power of Attorney is a more flexible and useful document, it benefits patients in two ways.

First, it allows a patient to appoint a decision maker (representative) of his or her choice. Second, it ensures that the patient's wishes are followed. In current hospital practice, the patient's wishes, even if known, may not always be followed. For example, even if a patient who has signed an organ donor card becomes brain-dead, his/her organs may not necessarily be donated. Hospitals routinely ask the next of kin for permission to procure organs, and it is not uncommon that permission is refused by the family even though the patient wanted to donate.

Family knowledge of a patient's advance directives can be of great benefit to them. Often families are asked to make decisions with physicians about whether or not to continue life-prolonging treatments for their family members. These decisions can promote a great deal of anxiety in families and often leave them with a feeling of guilt if they do not ask the physicians to do everything possible to sustain life. However, if the patient had completed a Medical Power of Attorney, the decision would not be left to the family, but rather to the patient's representative, who would make the decision based on what the patient would have wanted. It is much easier for a family to accept the withholding or withdrawal of a life-sustaining treatment if they know their family member would have refused it if able.

Advance directives benefit hospitals. It is reassuring to hospital personnel when a life-sustaining treatment is withheld or withdrawn, especially in a patient who might

have lived for an extended period of time, that the patient's wishes are being respected. Also, the use of advance directives can facilitate decisions about whether or not to employ cardiopulmonary resuscitation and mechanical ventilation in a critically ill patient who has lost decision-making capacity. Furthermore, in a time when intensive care unit beds are in short supply, the following of advance directives can allow the beds to be used for patients who are known to have wanted intensive care.

Advance directives are likely to benefit society. In a time when cost containment in health care is a priority, the use of advance directives can lead to a decrease in spending for expensive medical care that is not wanted by patients. For example, Nancy Cruzan's medical care is costing the state of Missouri over a $100,000 per year. It is apparent from the court testimony that she would not want this costly care. There are now estimated to be another 5,000 — 10,000 patients in a persistent vegetative state being kept alive in this country. Based on surveys of the American public, chances are very high that most of these patients would not want life-prolonging therapy.

Finally, advance directives benefit physicians. Often when a patient is very sick, the family cannot agree on whether or not life-prolonging medical treatment should be continued. In the absence of a family consensus, treatment is usually continued, even when the physician doubts its benefit, because he or she is concerned about being sued by unhappy family members. An advance directive provides the physician with a decision based on the patient's choice and provides legal protection for following this directive.

Taken together, advance directives provide a win-win situation for patients and their health care providers. Patients are ensured that their right to self-determination in health care will be preserved, and providers are protected from concerns about liability when they follow their patients' wishes. In the environment created by the recent legislation and court decisions, it is time for physicians to talk to patients about their health care wishes and to encourage them to complete advance directives.

Editor's Note: *Copies of Medical Power of Attorney forms and information about how to complete them will be available at the Mid-Winter Conference of the West Virginia State Medical Association in Charleston from January 25-27.*

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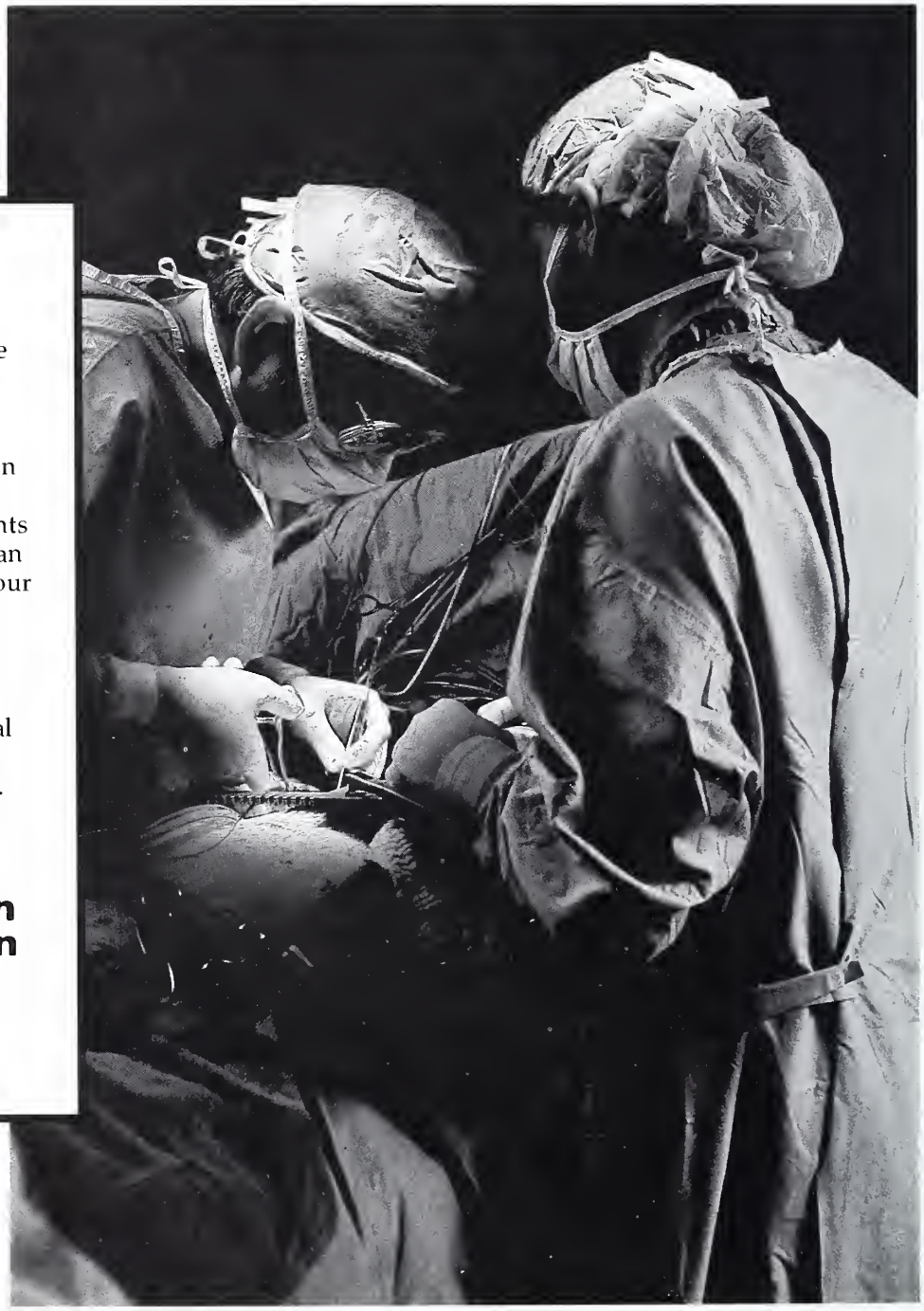

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Exclusion Bypass of a Difficult Abdominal Aortic Aneurysm

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Abstract

Aortic repair by graft replacement is currently the most generally accepted and widely used technique in the treatment of infrarenal abdominal aortic aneurysm. Many alternative approaches have been considered in order to limit the physiological stress of surgery. A recently described technique involves an extraperitoneal approach to the abdominal aorta, whereby the aneurysm is left insitu, excluded from arterial pressure, and an infrarenal aortic bypass is performed. In this case report, this exclusion bypass technique was safely applied through a transperitoneal approach to manage a very large, torturous and displaced infrarenal abdominal aortic aneurysm which was densely adherent to the left kidney and ureter.

Case Report

A 73-year-old male was admitted with non-specific abdominal pain, low back pain, malaise, and dysuria. His medical history was significant for nephrolithiasis, history of chronic back pain from severe scoliosis, hypertension, and peptic ulcer disease. He was afrebile and was noted to be orthostatic. Physical exam was remarkable for a non-tender 8 cm pulsatile mass in his lateral left upper quadrant. He had no back tenderness. He did have marked scoliosis of his lumbar spine. Laboratory workup included a hemoglobin of 16 g/dl, white blood cell count of 15,800, BUN of 21 mg/dl, creatine of 1.7 mg/dl, and urinalysis containing 10-20 WBC per HPF with rare RBC but many bacteria.

A diagnosis of abdominal aortic aneurysm (AAA) and concomitant urinary tract infection (UTI) was made. CT scan of the abdomen revealed a 10 cm abdominal aortic aneurysm with marked tortuosity toward the left upper retroperitoneum, displacing the left kidney and ureter anteriorly. Because of the marked tortuosity at the neck and proximal portion of the aneurysm, a double-lumen artifact was demonstrated by CT scan (Figure 1). After adequate intravenous hydration, subsequent aortography confirmed a large and extremely tortuous infrarenal AAA (Figure 2). In addition, there was aneurysmal involvement of the common iliac artery bilaterally.

After his UTI was adequately treated, the patient underwent transperitoneal repair of the AAA. At

Figure 1. CT scan demonstrates a "double lumen" artifact caused by marked tortuosity of the aneurysm. The left kidney and ureter are anteriorly displaced.

Figure 2. Aortography reveals an extremely tortuous infrarenal AAA with acute angulation at the aneurysmal neck.

Figure 3. At operation by transperitoneal approach, the neck of the aneurysm is exposed and isolated with umbilical tape. The right-angle kink at the neck is demonstrated.

Figure 4. The AAA has been excluded from arterial circulation with an aortobifemoral bypass graft. The aneurysmal sac was left intact.

the time of the operation, the left kidney and ureter were densely adherent to the anterior wall of the aneurysm. The main body of the aneurysm was deviated markedly to the left retroperitoneum. The neck of the aneurysm was isolated and was found to form a right angle at its midportion (Figure 3). The neck was doubly clamped at its immediate infrarenal and its most distal position. The aorta was then divided between the clamps at the level of the acute angulation. The upper end of the aneurysm was then over-sewn as currently done with aorta-femoral bypass for occlusive disease. An end-to-end proximal anastomosis was performed and the bifurcation bypass graft (dacron) carried distally to the common femoral arteries, which were previously exposed via groin incisions. Two-pole exclusion was completed by ligation of both iliac arteries. Distal anastomosis was performed in an end-to-side fashion to the common femoral artery bilaterally. The excluded aneurysmal sac was left insitu (Figure 4). Estimated lood loss was approximately 250 ccs.

The patient's subsequent hospital course was complicated by recurrent peptic ulcer disease, which resolved with H2 receptor antagonist therapy. When seen in the clinic six months postoperatively, the patient was doing well without complaint.

Discussion

Many alternative approaches have been considered after and before Dubost had performed the first repair of an abdominal aortic aneurysm (AAA) by resection and replacement graft in 1951 (1). The current popular approach to the infrarenal aortic aneurysm consists of transabdominal endoaneurysmorraphy first described by Creech in 1966 (2). Other approaches include aneurysm reinforcement, induction of thrombosis by intrasacular wiring, induction of thrombosis by direct approach followed by extra-anatomical bypass, and extraperitoneal aortic bypass with exclusion of the aneurysm (3-6). The latter two techniques were designed primarily to reduce the physiological stress imposed upon the patient at the time of surgery. The non-resective exclusion of aneurysm and inline aortic bypass via a retroperitoneal exposure has been shown by retrospective analysis to be a safe operation. Compared to the standard transperitoneal endoaneurysmorrphy, this operation was performed with decreased blood loss, requirement for transfusion, intensive monitoring, and need for intubation and nasogastric decompression (6-8).

The non-resective exclusion technique was utilized in this particular case for anatomical and technical reasons. The main course of the infrarenal aneurysm was displaced significantly to the left retroperitoneum secondary to the patient's scoliosis and the longitudinal expansion of the aneurysm. Complete intra-aneurysmal placement of the aortic graft as performed in standard (Creech) repair of AAA's would not have been anatomically possible. The risk of damage to the left ureter was completely avoided since dissection about the aneurysm except its neck was not required. A retroperitoneal approach combined with the non-resective exclusion method as described by Corson (6) and Leather (7) was considered prior to surgery. However, due to the acute angulation of the aneurysm neck with severe displacement of the voluminous aneurysm toward the left retroperitoneum, exposure of the infrarenal aorta was determined to be difficult via a retroperitoneal approach. The transperitoneal approach allowed direct and safe access to the neck of the aneurysm in this patient.

Exclusion-bypass has been widely used for many years in the treatment of peripheral aneurysms (9). This method has been proposed as an alternate to intra-aneurysmal grafting in the treatment of thoracic and thorocoabdominal aneurysms for selected patients (10, 11).

More recently, Leather reported a series of 133 patients with infrarenal AAA managed by the retroperitoneal approach whereby the aneurysm was left intact after division of the infrarenal aorta for an end-to-end proximal anastomosis of a tube or bifurcation graft (7). When compared to a similar group of patients treated by the conventional transperitoneal graft inclusion technique, no significant differences in morbidity or mortality were found. The traditional inclusion technique allowed significantly increased intraoperative blood loss. Leather's study supported the routine use of the retroperitoneal exposure combined with the exclusion technique for repair of AAA's. In our case report, the exclusion method was safely applied to the transperitoneal approach to manage a technically-difficult infrarenal AAA.

Conclusion

This case report demonstrated a successful transperitoneal exclusion bypass technique for repair of an anatomically-unusual infrarenal AAA. Extremely tortuous aneurysms may not allow intra-aneurysmal placement of a graft. By leaving the aneurysm insitu, blood loss can be kept to a minimum and damage to surrounding structures can be avoided.

While it has previously been advocated in combination with the retroperitoneal approach, the exclusion technique can be safely applied to the transperitoneal approach in repair of the difficult AAA.

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Post Menopausal Bleeding As a Risk Factor For Endometrial Carcinoma

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Abstract

From July 1985 to January 1989, 133 patients underwent endometrial sampling for evaluation of post menopausal bleeding (PMB). Of these patients, 114 (85.7 percent) showed benign histology with an average age of 58.6 years. Nineteen (14.3 percent) were malignant, all of which showed endometrial carcinoma. The average age was 65.

In addition, 26.3 percent of patients with carcinoma had higher grade of tumor at hysterectomy when compared with the preoperative biopsy. The average volume of tissue removed at curettage was significantly greater in those with carcinoma. Hormonal therapy, duration of symptoms, hypertension, obesity or diabetes were not significant risk factors for carcinoma in our series.

PMB remains a major symptom that may predict endometrial carcinoma and must be evaluated. In those patients with carcinoma, intraoperative evaluation of the uterus for tumor grade and depth of invasion is important in determining the extent of surgery.

Introduction

Cancer of the endometrium is the most common malignancy of the female genital tract. It is estimated that 35,000 women in the U.S. will develop uterine cancer this year, with 75 percent occurring after menopause (1).

Vaginal bleeding after menopause is therefore an alarming symptom. In earlier reports, between 53 percent and 90 percent of patients with post menopausal bleeding (PMB) had endometrial carcinoma (2-5). However, with the increasing availability of medical care more women with PMB are being evaluated. In more recent articles, the incidence of carcinoma in those with PMB has been reported to be 1.5 percent-13.5 percent (6-7).

The purpose of this paper is to review the author's experience at Marietta Memorial Hospital in the evaluation of patients with PMB.

Materials and Methods

From July 1985 to January 1989 (42 months), 133 patients in the author's practice were evaluated for PMB. PMB was defined as uterine bleeding occurring more than six months after menopause. All patients underwent either an endometrial sampling in the office using a Novak curette or a formal in-hospital

Table 1. Distribution of histology in endometrial curettage

Histology	*Number of Patients*	*Percentage*
Proliferative	47	41.2%
Atrophic	34	29.4%
Endometrial polyp with proliferative	12	10.6%
Inadequate tissue for evaluation	11	9.4%
Secretory	5	4.7%
Cystic and adenomatous hyperplasia	5	4.7%
Total	114	100%
Carcinoma	19	(14.3%)
Benign	114	(85.7%)
Total Cases	133	

fractional D&C under anesthesia. All records were reviewed for multiple parameters, age, parity, weight, duration of symptoms, location of biopsy (office vs. hospital), medications, evidence of hypertension, diabetes or other medical problems.

The tissue obtained was evaluated for histologic diagnosis and volume. All patients with endometrial cancer underwent primary surgery with hysterectomy and appropriate staging where indicated. In all cases, the uterus was opened intraoperatively and examined by the pathologist for tumor grade and depth of invasion. Tissue grading from the curettage was compared with the final hysterectomy specimen.

Statistical analysis was performed by the Department of Statistics, Marietta College, Marietta, Ohio.

Results

Of the 133 patients with PMB who underwent office or hospital endometrial curettage, the average age was 59.6 years (range 41-86) with 114 (85.7 percent) of these showing benign tissue. In addition, 19 (14.3 percent) were malignant, all of which showed endometrial adenocarcinoma.

The average patient's age for the benign cases was 59.6 years (range 41-86). The distribution of histology is listed (Table 1). Accordingly, 47 (41.2 percent) showed proliferative endometrium; 34 (29.4 percent) were atrophic; 12 (10.6 percent) had endometrial polyp, 5 (4.7 percent) were cystic or had adenomatous hyperplasia, and 5 (4.7 percent) contained secretory endometrium. Eleven of the benign specimens (9.4 percent) were inadequate for evaluation but showed no malignancy.

The 19 carcinoma patients were an average age of 65.9 years (range 48-86) and had residual tumor in the hysterectomy specimen. The change in grade from curettage to hysterectomy specimen is outlined (Table 2). Mixed grades were classified as the higher grade (e.g. grade II-III = III). The distribution of tumor by surgical stage is listed (Table 3).

Over the 42 months of the study, there was a shift from hospital evaluation to office endometrial sampling (Table 4). This correlated with an increase in the author's office referrals. With the increasing volume of patients with PMB, the percentage of patients with a malignancy also declined. The average number of pregnancies for both benign and malignant cases was three. The duration of PMB prior to curettage is listed (Table 5) and was not significantly longer in those with carcinoma ($p > 0.25$).

Due to small sample size, no significant difference could be demonstrated in the percentage of patients on estrogen therapy in those with benign (47 of 114 or 41.2 percent) vs. malignant histology (3 of 19 or 15.8 percent) ($p > 0.05$).

Table 2. Changes in histologic grade Pre-operative curettage vs. hysterectomy specimen

Carcinoma Grade of Hysterectomy Specimen	*Number of Patients*	*Percent*
I	9	47.4%
II	6	31.6%
III	4	21.0%
Total	19	100%
Changes in Grade of Carcinoma (Pre-op vs. Final Tissue)		
Upgrade	5	26.3%
Downgrade	0	0%
Unchanged	14	73.7%
(60% office-40% hospital)		

Table 3. Distribution of tumor by surgical stage

Stage	*Number of Patients*
I A	8
I B	5
I C	6
Total	19

Table 4. Number of patients having endometrial curettage in the office vs. hospital (7/85 - 1/89)

	Office	*Hospital*	*Total*	*Carcinoma*
1985	1 (14.3%)	6 (85.7%)	7	3 (42.9%)
1986	13 (36.1%)	23 (63.9%)	36	6 (16.7%)
1987	19 (57.6%)	14 (42.4%)	33	5 (15.2%)
1988	42 (73.7%)	15 (26.3%)	57	5 (8.8%)
Total	75 (56.4%)	58 (43.6%)	133	19 (14.3%)

Table 5. Average duration of vaginal bleeding prior to endometrial curettage

Benign = 8.2 weeks (range 1 day—104 weeks)
Carcinoma = 28.7 weeks (range 0—104 weeks)
Office Endometrial Biopsy = 9.6 weeks
Hospital Curettage = 12.6 weeks

Table 6. Average volume of tissue removed at curettage

Tissue Volume

Office Endometrial Biopsy = 2.6 cc
Benign 2.2 cc Carcinoma 7.3 cc — Carcinoma Total — 21.5 cc

Hospital Curettage = 9.7 cc
Benign 5.5 cc Carcinoma 34 cc — Benign Total — 3.6 cc

Table 7. Reasons for performing hospital curettage

	Reasons for Hospital D&C — Number of Patients				
Final Tissue Diagnosis	*No Stated Reason*	*Cervical Stenosis*	*Consult In Hospital*	*Patient Request*	*Total*
Carcinoma	7 (63.6%)	2 (18.2%)	2 (1.2%)	0	11
Benign	25 (53.2%)	17 (36.2%)	3 (6.4%)	2 (4.2%)	47
Total	32 (55.2%)	19 (32.8%)	5 (8.6%)	2 (3.4%)	58

Of people with hospital D&C's 11 of 58 (19%) had carcinoma
Of people with office biopsies 8 of 75 (10.7%) had carcinoma
Total patients with carcinoma 19 of 133 (14.3%)

The average volume of tissue removed with curettage was significantly greater with the hospital D&C vs. office endometrial sampling ($p=0.018$), as shown in (Table 6). The volume of tissue in those with carcinoma was also greater than those with benign tissue ($p=0.03$).

Patients with benign histology (84 of 114 or 73.7 percent) and 15 of 19 cases (78.4 percent) with carcinoma had either hypertension, obesity or diabetes or a combination of any of these. There was no significant difference in the two groups ($p=0.31$).

The reasons that the endometrial sampling was done in the office vs. the hospital are outlined (Table 7).

Discussion

Carcinoma of the endometrium continues as the most common genital tract malignancy (8). Multiple risk factors have been identified including obesity, hypertension, diabetes, multiparity, late menopause and estrogen replacement therapy (9).

In our series, however, the number of people on estrogen replacement therapy was not significantly greater than in those with benign histology. Additionally, there was no significant difference in the number of patients with benign vs. malignant disease in those with hypertension, diabetes and/or obesity. The reported median age for endometrial carcinoma is 61 (1). While the premenopausal and perimenopausal patient with abnormal uterine bleeding must be considered at risk, the most common presenting symptom is post menopausal bleeding.

Of the 133 patients evaluated in our series for PMB, 19 (14.3 percent) had invasive carcinoma of the uterus. As noted, this percentage continued to decrease during the study as more people were evaluated. This compares favorably with the other reported series and does re-emphasize the importance of evaluating any patient with PMB (9).

The comparable accuracy of office vs. operating room endometrial curettage has been documented (10-15). Advantages for the office procedure include lower cost and decreased risks associated with anesthesia (16).

While the volume of tissue removed in the office is less than a curettage under anesthesia at the hospital, this does not appear to be significant for diagnosis. In our series, the volume of tissue removed in those patients with carcinoma was significantly greater than in those with benign histology. This is a factor many gynecologists have noted in clinical practice.

In those patients diagnosed as "benign," it is conceivable they are still exposed to similar carcinogenic stimuli as those with carcinoma but have merely been evaluated at an earlier point in the disease process. A negative evaluation, therefore, does not preclude appropriate follow-up in the future for the development of carcinoma. It will be of interest to follow the 114 patients with benign histology to compare their risk of developing endometrial carcinoma with the general population without PMB.

There was a change in grading (upgrading) in 26.3 percent of carcinoma cases when comparing the preoperative curettage with the hysterectomy specimen. This certainly can alter the extent of surgery and further emphasizes the need for intraoperative evaluation of the uterus for depth of invasion and grade (17).

Conclusions

Endometrial carcinoma is likely to remain a major problem in our lifetime. Evaluation of the high-risk patient and especially those with post menopausal bleeding will yield a significant number of patients with carcinoma. Hopefully, earlier diagnosis will provide a greater opportunity for cure. The office endometrial sampling remains an appropriate, cost-effective and accurate method for early detection.

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Use double spacing throughout, including (in the following order) title page, abstract, text, acknowledgements, references, tables, and legends for illustrations. Begin each of the following sections on separate pages: title page, abstract, text, acknowledgements, references, individual tables, and legends for illustrations. Number pages consecutively, beginning with the title page. Type the page number in the upper right-hand corner of each page.

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Tables (tabular listings) and figures (photos, drawings and charts) should be numbered and the point of reference in the text indicated in parentheses, i.e., (Table 1), (Figure 1).

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President's Page

Michael M. Stump, M.D.

The Best and Worst of Times

Charles Dickens opens his novel "A Tale of Two Cities" with the statement, "It was the best of times and the worst of times."

As we enter the decade of the 90s, medicine might well make the same claim regarding itself.

With the preparation of this page during the joys and blessings of the holiday season, I would like to think on a few of the good things about medicine and our profession. I can speak with a certain authority since I am alive only by the grace of the medical technology practiced in the 80s. I would have been dead under the technology of the 60s.

As we enter the 90s, we marvel to behold the accelerating technologies in the physical sciences, the biological sciences, the life sciences, and the medical sciences. We live in a world of near miracles as we apply the good of our technology in the care of the sick. Life and health is now sustained and restored where it would have been lost before. We less frequently have to fall back on the statements "It can't be helped," or "There is nothing more we can do."

Information is exploding by quantum leaps. The doubling time of new facts is shortened beyond belief. We are at a point our forefathers would have never imagined.

CT scans are used routinely along with MRI. Ultrasound is becoming increasingly sophisticated. Nuclear imaging continuously upgrades and will likely replace invasive arteriography after a period of time.

Lithotripsy shockwaves break up renal stones and the gallbladder is removed through the laparoscope with the aid of miniature lenses and TV cameras. Microsurgery is very common.

With flow cytometerity and diagnostic molecular pathology, we now study the nuclear DNA content of malignant tumor cells which results in better diagnoses and treatments. Immunological techniques have become invaluable in the treatment and diagnosis of varieties of conditions.

New pharmaceuticals and medications are discovered almost weekly and effect beneficial changes in our body which allow us to live longer and better.

We see the beginning uses of genetic manipulation to treat diseases and we are crossing the frontier border of undreamed possibilities. New eras continue to unfold before our eyes.

As a result of all these wonderful advances, we may ultimately see the life expectancy of a responsible and healthy person living in a healthy environment extend to the 12th decade.

We have arrived at a point that the good we do collides with the basic social precepts of resource allocation, cost benefit analysis, and social financial priorities.

The clashes among the various goods have engendered serious debate concerning the balancing of individual and social justice. There is renewed discussion regarding the obligations of the individual towards society as well as society towards the individual. However, there is still just a glimmer of discussion regarding the obligations of the individual towards himself as a person.

According to author Gene Outka, the following five concepts should be considered regarding health care:

1. To each according to his merit or desert.
2. To each according to his societal contribution.
3. To each according to his economic success in a free market-place of supply and demand.
4. To each according to his needs.
5. To all similar treatment for similar cases.

This debate is lively and ongoing and is leading us to consider solutions not before examined. It is also helping us to consider our profession and look at its essential meaning.

Physicians must be true to medicine's professional integrity. We are enlisted on the side of life and health. We care for the sick with humility and are dedicated to our patients. Our truthfulness and identity is committed to that care, and outsiders shall remain outside of the sanctity of the patient-physician relationship.

We are trying to help society reach a fundamental understanding of personal responsibility for their individual health — that there is a personal, individual and social obligation to live a knowledgeably healthy life and be accountable for individual actions and decisions.

This is an effort worthy of us all.

Michael M. Stump. M.D.

New Year's Predictions

Seers make their appearance at this time of year. Looking into the future somehow captivates each one of us at the beginning of every new year. We manage to take comfort in making tomorrow predictable even when those glimpses of things to come must appear to be grim. Perhaps this is so because anticipating misfortune often seems to have the magical effect of diverting or dissipating that misfortune.

We could use a magical spell of some kind to improve our lot in West Virginia. God knows, the governor and Legislature have shown competence only in making things worse — particularly so in Medicine.

Maybe it just seems as though Medicine is being picked upon more than any other business, profession or identifiable group. In actuality, we might just be suffering our turn. Others may have already passively accepted their fate in the homogenizing blender of industrial or professional mediocrity.

My New Year's predictions include:

1. Tort reform measures will be introduced in the West Virginia Legislature, but no bills on the subject will emerge from Senate or House committees;

2. Blue Cross/Blue Shield will never regain the trust of doctors, patients, or employers in West Virginia and, in the remainder of the states, will come under increasingly stringent and perhaps crippling regulations;

3. Starting with obstetrics, crises in the provision of specialty care will erupt in multiple areas of West Virginia, and this will require ailing West Virginians to leave the state to obtain specialty care;

4. Many of West Virginia's best doctors will quit practice or leave the state to practice elsewhere, resulting in a net loss of physicians in West Virginia;

5. More, and more loathsome, plaintiff attorney-sponsored television commercials encouraging West Virginians to sue one another will foul television viewing rooms throughout West Virginia;

6. PEIA will end the year with new records in back-logged unpaid bills;

7. Our good governor and his staff will monitor these and other developing disasters with an effectiveness equal to that shown from the bridge of the Titanic.

We all *know* that the things we think about and visualize in our minds never happen. It's only those things we don't expect — those surprises — that cause all the misery.

Does that mean worse things, unmentioned, not on our list, even unthought of things might lie in wait? God forbid! But if we could only think of them, write them down, we might, with some good magic, make them evaporate like mist from our beautiful hills.

I suspect our governor also uses a problem-solving technique similar to the above. I wonder what his New Year's list of predictions might be.

Stephen D. Ward, M.D.

Our Readers Speak

In Agreement on Rockefeller

It was my pleasure to read the recent editorial in the *West Virginia State Journal*. I also feel that Jay Rockefeller would be an asset in the executive position nationally.

This is fortunately the first time that I have been able to agree with you on an issue that you have expressed in the *Journal*.

Thank you,

Louis F. Ortenzio, M.D.
101 Stoneybrooke Road
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Editor's Note: *It's reassuring to find that we finally got something right.*

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FRIDAY, JANUARY 25--Adolescent Health--2 to 5 PM

"Pathophysiology and Radionuclear Treatment of Thyroid Disease"--John W. Leidy, Jr., MD, PhD, Huntington; "Diagnosis and Medical Treatment of Thyroid Disease"--Doug Jones, MD, White Sulphur Springs: "Thyroid Nodules - 1991 Approach"--Caldwell Esselstyn, Jr., MD, Cleveland, OH

SATURDAY, JANUARY 26--Controversies in Medicine--9 to Noon

"Laproscopic Cholecystectomy"--Roberto E. Kusminsky, MD, Charleston; "Conventional Surgery - Cholecystectomy"--Carl J. Kite, MD, Wheeling; "Effective Care for Acute Low Back Pain: What Every Physician Should Know"--Sandy Burkart, PT, PhD, Morgantown; "Back Pain - Surgically Correctable Problems"--Howard H. Kaufman, MD, Morgantown; "Controversies in Carotid Endarterectomy"--Ali AbuRahma, MD, Charleston; "Carotid Bruits: The Case Against Carotid Endarterectomy"--Jack Riggs, MD, Morgantown

SATURDAY, JANUARY 26--Trauma Management--2 to 5 PM

"Discontinuation of Mechanical Ventilation"--Hoyt J. Burdick, MD, FACCP, Huntington; "Head Trauma in the 1990's"--John Schmidt, MD, Charleston; "Level I Trauma Center"--Greg Timberlake, MD, Morgantown; "Blunt Abdominal Trauma"--Jim Boland, MD, Charleston

SUNDAY, JANUARY 27--Potpourri of Topics - Update--9 to Noon

"Aids Update"--Jaime E. Hernandez, MD, Huntington; "Fibrinolytic Therapy"--David Booth, MD, Lexington, KY; "Management of Malignant Ventricular Arrhythmias: CAMC Experience"--Ronald J. McCowan, MD, Charleston; "Transplantation: An Overview"--Shunzaburo Iwatsuki, MD, Pittsburgh, PA

ADVANCE REGISTRATION

Please register me for the 24th Mid-Winter Clinical Conference January 25-27, 1991, at the Charleston House Holiday Inn, Charleston.

Conference Registration Fee $_____

($75 WVSMA Members and PAs/$150 Non-Member)*

Please make check payable to WVSMA, and mail to PO Box 4106, Charleston, WV 25364

NAME _____ SPECIALTY _____

ADDRESS _____

*There is no registration fee for residents, medical students and nurses.

Rationing of Care, Adolescent Sexual Behavior Topics for Mid-Winter Physician/Public Sessions

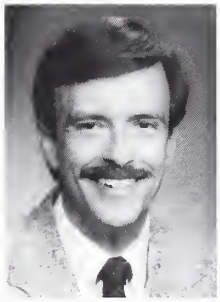
Willis Miller

Richardson

Moss

Bowers

Chamberlain


Keeling

Turner

Wallace

This year's concurrent sessions during the 24th Mid-Winter Clinical Conference in Charleston, January 25-27, will feature a panel discussion for physicians on "The Rationing of Care," and a public forum on "Adolescent Sexual Behavior: Problems and Solutions."

These concurrent sessions will take place from 7 p.m. - 9 p.m. on Friday, January 25 at the Holiday Inn-Charleston House. Michael M. Stump, M.D., WVSMA president, will moderate the physician session, and William N. Cunningham, M.D., a member of the Mid-Winter Program Committee, will conduct the public session.

Featured speakers for the physician session are Taunja Willis Miller, secretary of the West Virginia Department of Health and Human Resources; Sally Richardson, director of the Public Employees Insurance Agency; Alvin "Woody" Moss, M.D., director of the West Virginia University Center for Health Ethics and Law; and Barbara Bowers, M.D., of Minneapolis, Minn. The panelists for the public presentation will include Allan Chamberlain, M.D., M.P.P.M., of Huntington; Richard Keeling, M.D., director of the Department of Student Health at the University of Virginia; Linda Turner, coordinator of the Family Life Program in Huntington; and William Wallace Jr., M.D., commissioner of the Bureau of Public Health for the West Virginia Department of Health and Human Resources.

Biographical information of each of these speakers begins below and details on some of the other Mid-Winter programs are also featured in this General News section.

Panelists for Physician Session

Taunja Willis Miller currently serves as the secretary of the West Virginia Department of Health and Human Resources. In this capacity, she oversees the operation of the Divisions of Health, Human Services, Employment Security and Worker's Compensation, as well as the administration of the Human Rights Commission, the Commission on Aging and the Health Care Cost Review Authority.

Prior to her appointment, Ms. Miller was commissioner of the Department of Human Services. She was also a partner at the law firm of Jackson and Kelly.

Ms. Miller's academic background includes a bachelor's degree in political science and a law degree from West Virginia University.

Sally K. Richardson was deputy commissioner of the Department of Human Services for Research, Planning, Evaluation, Quality and Fraud and Abuse Control before accepting her present role as director of the Public Employees Insurance Agency.

During her career, Ms. Richardson has also been the deputy director of the West Virginia Department of Health and was the first chair of the West Virginia Health Care Cost Review Authority. Futhermore, Ms. Richardson served on the Human Resources Staff Advisory Council of the National Governors Association and the Task Force on Southern Children of the Southern Growth Policies Board.

A charter member and former secretary of the Health Care Coalition of West Virginia, Ms. Richardson is now a board member for two of the programs for Greater Kanawha Valley United Way, the Volunteer Management Assistance Program and Daymark.

Ms. Richardson is a member of the American Health Planning Association, the American Public Health Association, the National

Rural Health Association and the Association for Health Services Research.

Dr. Alvin "Woody" Moss received a bachelor's degree in social relations at Harvard College in 1971 and then attended the University of Pennsylvania for his medical degree. He did postgraduate training in internal medicine at North Carolina Memorial Hospital in Chapel Hill, N.C., from 1975-78, and then completed a renal fellowship at the University of Colorado Health Sciences Center.

From 1980-83, Dr. Moss worked as a staff physician at three hospitals in Greensboro, N.C., and also was an assistant clinical professor of medicine at the University of North Carolina School of Medicine in Chapel Hill. In 1983, he relocated to West Virginia to become an assistant professor of medicine at WVU and medical director of Hemodialysis for the Renal Dialysis Unit at WVU Hospital. Two years later, Dr. Moss assumed a new role as medical director of the West Virginia Health Care Cooperative Dialysis Program and became a consulting physician at Davis Memorial Hospital in Elkins and United Hospital Center in Clarksburg. In 1986, Dr. Moss was promoted to his current post as an associate professor of medicine at the WVU Health Sciences Center and was named president of Mountain State Organ Procurement, a position which he held until 1988.

During the 1980s, Dr. Moss's involvement with dialysis and transplantation lead him to complete studies in medical ethics at the Kennedy Institute of Ethics of Georgetown University and the University of Chicago Center for Clinical Medical Ethics. In 1987, he was instrumental in the formation of the West Virginia Network of Hospital Ethics Committees and this past year, he took sabbatical leave to participate in the National Leadership Training Program for Physicians in Clinical Medical Ethics at the University of Chicago. Dr. Moss was one of only eight physicians in the nation who have been chosen to participate in this program in the past three years. In 1990, he was named director of the new Center for Health Ethics and Law at WVU.

A board certified internist and nephrologist, Dr. Moss is chairman of the Hospital Ethics Committee at WVU Hospital.

Dr. Barbara J. Bowers received her medical degree from the University of Minnesota Medical School in Minneapolis, Minn., in 1976 and did a three-year residency in internal medicine at Abott-Northwestern Hospital, which is also located in Minneapolis.

In 1979, Dr. Bowers became chief resident at Abbott-Northwestern and an instructor in internal medicine at the University of Minnesota. The following year, she accepted a two-year medical oncology fellowship at the University of Minnesota Masonic Hospital and then opened her private practice for medical oncology in Minneapolis.

Dr. Bowers is president of the Minnesota Chapter of the American Society of Internal Medicine and chairs this organization's National Bylaws Committee. In addition, she is a member of ASIM's Committee on Payment for Physician Services and is also chief of Internal Medicine at the North Memorial Medical Center.

Panelists for Public Session

Dr. Allan Chamberlain obtained a bachelor's degree in psychology from Vassar College in 1977, a master's degree in public and private management from the Yale School of Organization and Management in 1979, and his medical degree from the University of Cincinnati in 1983. He did his postgraduate studies in obstetrics and gynecology at the University of Michigan Hospitals in Ann Arbor and WVU Hospital in Morgantown.

Dr. Chamberlain moved to Huntington in 1987 to become a clinical professor of obstetrics and gynecology, and pediatrics at Marshall University. Simultaneously, he was named to his other present post as director of Reproductive Health Programs for the Valley Health Systems, Inc., in Huntington.

In 1989, Dr. Chamberlain was voted Volunteer Clinician of the Year by the Marshall medical students. Active in community and state medical activities, Dr. Chamberlain serves on the board of directors for the Tri-State Compass Project, a United Way program designed to access the social service needs of the cities of Huntington, Ashland and Ironton. He is also on the advisory boards of the Local Availability Project in Charleston, which encourages mid-level providers to practice obstetrics in rural areas of West Virginia, and of the Youth Health Center in Huntington.

Dr. Richard Keeling obtained his medical degree from the University of Virginia at Charlottsville, completed six years of postgraduate studies at the school and then joined the faculty.

Before accepting his two current roles as director of the Department of Student Health at the University of Virginia and an associate professor of internal medicine, Dr. Keeling was a clinical instructor in nursing and an attending physician at the university's hospital.

Dr. Keeling is the president of the Foundation for Health in Higher Education and chairman of the Task Force on HIV Infection and AIDS for the American College Health Association. A Fellow of the American College Health Association, Dr. Keeling received this organization's Edward Hitchcock Award in 1990 for outstanding service in the field of college health and he has also received numerous other awards for contributions to medicine and public health.

Linda Turner has spent the last seven years coordinating the Family Life Program in Cabell County, which she created to help teachers instruct students from fifth grade level and up about human reproduction, puberty and sexually transmitted diseases. This program utilizes volunteers from Huntington's medical community and the Auxiliary to the Cabell County Medical Society, who assist teachers in the presentation of these subjects to students.

In addition to directing the Family Life Program, Mrs. Turner is very active in the Cabell County Medical Auxiliary. She and her husband, Dr. Charles Turner, reside in Huntington.

Dr. William Wallace Jr. graduated from the University of Vermont with

his medical degree in 1961 and then did a one-year internship at Methodist Hospital of Indiana in Indianapolis. From 1962-64, Dr. Wallace served with the U.S. Public Health Service Division of Indian Health, working at Hastings Hospital in Tahlequah, Okla.

In 1965, Dr. Wallace obtained a doctorate degree in tropical medicine and hygiene from London University and relocated to Ganta, Liberia, where he devoted himself to missionary medicine and public health for 11 years. During this time, Dr. Wallace earned a master's degree in public health from Johns Hopkins University School of Public Health and Hygiene.

Following his years in Liberia, Dr. Wallace returned to the U.S. and worked from 1976-90 in Concord, N.H., first as the director of the Bureau of Crippled Children's Services, then in three administrative roles for the Department of Health and Welfare. In October 1990, Dr. Wallace accepted his present title as commissioner of the Bureau of Public Health and Human Resources in Charleston.

A Fellow of the American College of Preventative Medicine, Dr. Wallace received the Ira Vaughn Hisock Award in 1990 for excellence in public health.

MU Residents Present Papers

The Marshall University Department of Surgery had two papers presented by residents at the 84th Annual Scientific Assembly of the Southern Medical Association, which was held at Opryland in Nashville, Tenn., October 14-17.

A paper on "Flexible Sigmoidoscopy Screening for Asymptomatic Colorectal Disease: Inguinal Hernia Patients vs. Normal Patients" was presented by Steve Wilson, M.D. Co-authors were William E. Wheeler, M.D., Jane A. Kurucz, M.D., Jackson Flanigan, M.D., David Ratliff, M.D., and previous faculty member, Carroll Scott-Conners, M.D., who is now at the University of Mississippi.

The second paper, "Extremities, Soft Tissue Sarcomas" was presented by Jackson Flanigan, M.D., with co-authors, William E. Wheeler, M.D. and James P. Carey, M.D.

Other Mid-Winter Seminars, Meetings

Thursday, January 24

"Practical Applications for Maximum Reimbursement" - A Coding and Billing Workshop for Physicians, Office Managers and Billing Clerks
Instructor: Harold Preston, vice president, Physicians' Practice Management, Charleston — 10 a.m. - 2:30 p.m.

"Politics, The Media and You" - A Public Relations Seminar for Physicians and Auxilians
Presenters: Linda Arnold, president, The Arnold Agency, and Larry Swann, former House Minority Leader — 1 p.m. - 4:30 p.m.

WV Chapter/American College of Physicians
Registration and Reception — 5 p.m. - 7:30 p.m.
Break-out Sessions — 7 p.m. - 9 p.m.

WVSMA Legislative Reception — 6 p.m. - 8 p.m.

Friday, January 25

WV Chapter/American College of Physicians
Scientific Session — 8 a.m. - noon

WVSMA Executive Committee Meeting — 8:30 a.m. - 11:30 a.m.

WVSMA Component Society Presidents and Executive Secretaries Luncheon — Michael M. Stump, M.D., presiding — 11:30 a.m.

American Academy of Family Physicians Legislative Committee Luncheon — William B. Ferrell Jr., presiding — 11:45 a.m.

"What West Virginia Physicians Need to Know About Advance Directives," Alvin H. Moss, M.D., director of the WVU Center for Health Ethics and Law, 1 p.m. - 1:30 p.m.

Reception — Sponsored by WVU Alumni Association — 5:30 p.m. - 7 p.m.

WVSMA Medical Student Section Meeting — Derrick L. Latos, M.D., presiding 5:30 p.m. - 7 p.m.

Saturday, January 26

WVSMA Committee on Medical Education Breakfast Meeting — William O. McMillan Jr., M.D., presiding — 7:30 a.m.

WVSMA Sports Medicine Committee — David Avery, M.D., presiding — 8 a.m.

WV Academy of Ophthalmology Luncheon Meeting — James Genin, M.D., presiding — noon

WV Chapter/American College of Physicians Council Luncheon Meeting — noon

WV Psychiatry Association — Paul Clausell, M.D., presiding
"Use and Misuse of Benzodiazepines"
Speaker: Randy Canterbury, M.D., associate professor, Department of Behavioral Medicine and Psychiatry, University of Virginia — noon

WVSMA Young Physicians Section Luncheon Meeting — David W. Avery, M.D., presiding
Speaker: Ibetesam Sue Barazi, industrial hygiene supervisor, U.S. Department of Labor, Occupational Safety and Health Administration — noon

WVSMA Legislative Agenda - Michael M. Stump, M.D., presiding — 1 p.m.

Reception — Sponsored by CNA Insurance and McDonough Caperton Insurance Group — 6 p.m. - 7:30 p.m.

Sunday, January 27

WVSMA Cancer Committee Breakfast Meeting — Catalino B. Mendoza Jr., M.D., presiding — 7:30 a.m.

Continental Breakfast — Hosted by CNA Insurance and McDonough Caperton Group — 8:00 a.m.

CNA Third Generation Loss Control Presentation — 8:30 a.m.

WVSMA Council Meeting — Derrick L. Latos, M.D., presiding — 12:30 p.m.

Ohio County Medical Society/Auxiliary Sponsor Health Awareness Week

Steve Seekins, vice president of special projects for AMA, addresses the members of the Ohio County Medical Society and Auxiliary at the special joint dinner meeting they held during Health Awareness Week.

To increase community awareness of current health issues, the Ohio County Medical Society and their Auxiliary co-sponsored "Health Awareness Week," from November 26-30.

Each day of Health Awareness Week, as it was officially proclaimed by the city of Wheeling, was devoted to activities and presentations focusing on AMA's Health Access America program.

This special event began with a dinner on Monday, November 26 in honor of 12 seniors from four Wheeling area high schools who presented their ideas on how to improve the delivery of health care in the U.S. The next day, seminars were conducted for senior citizens to educate them on the cost of health care and how "socialized" medicine would affect them. A mini-health fair at Wheeling Jesuit College was held on Wednesday, with wellness credits given to participating students. As part of the fair, a physician spoke to one of the philosophy classes about health care topics and a representative from Brook Wellness Center talked with students and faculty about healthy lifestyles.

On Thursday to highlight and conclude the week, Steve Seekins, vice president of special projects for AMA, gave an update on the Health Access America program at a joint dinner meeting of the Ohio County Medical Society and the Auxiliary. Following the dinner, Dr. James Comerci, president of the Ohio County Medical Society, moderated a public forum with four panelists discussing the future of health care. The panelists for the Wheeling forum were David Grubb, a member of the West Virginia House of Delegates; James Bowen, director of United Steel Workers District 23; Dr. Derrick Latos, immediate past president of the West Virginia State Medical Association; and John VanSklaar, chief executive officer of Health Guard.

According to Louann Fagundo, president of the Auxiliary to the Ohio County Medical Society, and Kathy Fortunato, vice president of the Auxiliary and co-chairman of Health Awareness Week, the event received excellent media coverage and plans are in motion to hold it on an annual basis.

Moderator Dr. James Comerci, president of the Ohio County Medical Society, comments on a question from the audience during the public forum on health care in Wheeling. Seated to his left are panelists Dr. Derrick Latos, John Vansklaar, James Bowen and David Grubb.

Annual Ophthalmology Conferences Announced

The WVU Department of Ophthalmology will hold their Second Annual Ophthalmology Alumni Weekend on March 8 and 9 in Morgantown.

Featured speakers will be Albert Jonsen, Ph.D., a Susruta Lecturer from the University of Washington; and Thomas R. Mazzocco, M.D., director of a phacoemulsification course in Van Nuys, Cal.

In addition, the West Virginia Academy of Ophthalmology will have their 44th Annual National Spring Meeting, April 25-28, at The Greenbrier in White Sulphur Springs.

This conference will include presentations by Herve M. Byron, M.D., Robert E. Fenzl, M.D., B. Thomas Hutchinson, M.D., Philip A. Shelton, M.D., J. D., and George W. Weinstein, M.D.

For more information about the meetings, contact Patricia Schumann at 293-3757.

Fact Sheet Printed About Medical Exams

The Medical and Insurance Committee of the President's Committee on Employment of People with Disabilities has released a fact sheet on: "Medical Examinations: Are They Beneficial and Legal?"

This fact sheet presents the rationale for pre-placement medical examinations, the benefits to be gained from them, and the legislated conditions of the Americans With Disabilities Act under which they may be conducted. It also suggests content for such examinations and provides sources of additional information.

The publication is directed to employers, health care and human resources personnel, labor union officers, risk management and safety professionals.

Copies of this fact sheet may be obtained free by writing to the President's Committee on Employment of People with Disabilities, Suite 636, 1111 20th Street NW, Washington, D.C. 20036; or by telephoning 202-653-5044.

CME Cruise/Seminars Scheduled

For the 12th consecutive year, International Conferences of Fort Lauderdale, Fla., will sponsor a series of cruise/seminars on medicolegal issues.

These seminars have been approved by The School of Medicine, State University of New York at Stony Brook, for 18-28 credit hours in Category 1 (AMA/PRA). The seminars have also been approved for 18-28 prescribed hours by the American Academy of Family Physicians.

The seminars will be held in conjunction with cruises to the Caribbean, Alaska/Canada, Western Mediterranean, Scandinavia/Russia, Trans Panama Canal, Western Europe, and New England/Canada. All seminars have been planned to comply with current IRS requirements.

For additional information, contact International Conferences, 1290 Weston Rd., Suite 316, Fort Lauderdale, Fla. 33326, (800) 521-0076 or (305) 384-6656.

Head/Neck Anatomy Course Offered

A four-day course entitled "The Alton D. Brashear Postgraduate Course in Head and Neck Anatomy," will be held at the Medical College of Virginia, Department of Anatomy, March 4 - 7.

Lectures and demonstrations will augment the laboratory work. The course is approved for 40 elective hours by the American Academy of General Practice and Academy of General Dentistry.

Further information may be obtained from Dr. Hugo R. Seibel, Department of Anatomy, Box 709, Medical College of Virginia, Richmond, Virginia 23298.

Contraceptive Implant System Approved by FDA

FDA has approved the first implantable contraceptive for marketing in the United States. The approval was for levonorgestrel implants (the Norplant System), a long-term (up to 5 years), highly effective, reversible contraceptive.

Unlike other contraceptive methods, except IUDs and sterilization, the efficacy of the Norplant System does not depend on patient self-medication. The cumulative pregnancy rate for the product over 5 years is 1.1 percent. It prevents pregnancy through at least two mechanisms: ovulation inhibition and thickening of the cervical mucus.

The Norplant System consists of six flexible, closed, tubular capsules, each containing the progestin levonorgestrel. The product does not contain estrogen. The capsules are inserted beneath the skin of the upper arm. The implants should be removed after 5 years and, if desired, new ones inserted at that time.

Successful use and eventual removal of the Norplant System depend on a careful and correct subdermal insertion of the capsules. Infection and tissue trauma are possible, especially if physicians and other health professionals do not adhere to proper techniques of insertion and removal. The product's distributor, Wyeth-Ayerst Laboratories, is marketing the Norplant System as a kit with detailed instructions in the labeling on insertion and removal. In addition, Wyeth-Ayerst will offer extensive physician training programs. Physicians should not hesitate to remove the contraceptive if a patient requests it.

For further information about the Norplant System and physician training, contact Wyeth-Ayerst Laboratories, attention: Medical Affairs, P.O. Box 8299, Philadelphia, Pa. 19101-1254. In addition, Wyeth-Ayerst has set up an 800 number for questions about Norplant: 1-800-777-6180 (8:30 to 4:30 EST).

Kamath, McLellan Named Cancer Liaison Physicians

C. Ramadas Kamath, M.D., FACS, of Martinsburg, and David M. McLellan, M.D., FACS, of Fairmont, have received three-year appointments as cancer liaison physicians for the Commission on Cancer of the American College of Surgeons.

Drs. Kamath and McLellan are among a national network of 2,300 volunteer cancer liaison physicians who provide leadership and support to the Hospital Cancer Program and other Commission on Cancer activities. Dr. Kamath will be serving as the cancer liaison physician at the VA Medical Center in Huntington and Dr. McLellan will hold this same title at Fairmont General Hospital.

Established in 1956, the Commission on Cancer, which is composed of Fellows of the College and liaison members representing 23 other cancer-related organizations, has approved more than 1,200 cancer programs in hospitals across the country. The Commission reviews each hospital's cancer program for conformity to high standards set by the Commission, and encourages participating hospitals to equip and staff themselves so that they are able to provide the best in the diagnosis and treatment of cancer.

For more information on the Cancer Liaison Physician Program, the Hospital Cancer Program, or the Commission on Cancer, please contact the Cancer Department at the American College of Surgeons, 55 East Erie Street, Chicago, IL 60611, (312) 664-4050.

NCCHC Announces Call for Papers

The National Commission on Correctional Health Care (NCCHC) announces a Call for Papers for its 15th National Conference to be held on September 23-25 in San Antonio, Texas. The conference is expected to draw 1,000 physicians, nurses, dentists, administrators, and other health care professionals working in prisons, jails, and juvenile confinement facilities nationwide.

Presentations may cover one or more issues concerning health treatment and services in correctional institutions (jails, prisons, and juvenile confinement facilities). Topics of particular interest include: computer applications, cost containment, staffing, budgeting for health care for inmates, providing dental care, drug utilization review procedures, efficient pharmacy systems, food service/dietary concerns, mental health programs, juvenile health issues, and future trends of corrections and health care.

Programs generally last one hour and presentations that incorporate "hands on" teaching, audience participation, lively discussion, etc. are particularly desired. Speakers are requested to prepare handout materials to augment their oral presentations.

Deadline for receipt of abstracts is April 1. Persons interested in submitting a proposal should send a short abstract (no more than 250 words) and a brief description of the proposed target audience and educational goals to: Abstracts, National Commission on Correctional Health Care, 2105 N. Southport, Suite 200, Chicago, IL 60614.

Urological Society Plans Spring Meeting

The Annual Spring Meeting of the West Virginia Urological Society will take place March 22-24 at the Charleston Marriott. Featured speakers will be Professors Fray Marshall and John Gearhart of Johns Hopkins University.

Topics will include adult and pediatric renal and adrenal tumors and continent urinary reconstruction in pediatric pelvic neoplasms.

For details or registration contact: Douglas E. McKinney, M.D, 11 Chenoweth Drive, Bridgeport, WV 26330, 623-1001.

Continuing Education

Listed on this page are some of the upcoming continuing education programs which will be held throughout the state.

The programs this month were compiled by the following individuals: Suzanne Nowell, WVU outreach coordinator of continuing medical education; C. K. Datta, M.D., president of the Harrison County Medical Society; Robin Rector, coordinator of continuing medical education for Charleston Area Medical Center; and Arlene S. Feder, M.D., coordinator of Medical Grand Rounds for Ohio Valley Medical Center.

These programs are tentative and subject to change. Further information about these CME activities may be obtained by calling Nowell at 293-3937; Datta at 624-2309; Rector at 348-9580; and Feder at 234-1835. Other national and state meetings are listed in the Medical Meetings section of the *Journal.*

This schedule is presented as a convenience for physicians. If you would like to have the continuing education programs offered by your institution or association published in the *Journal,* please contact Nancy Hill, managing editor, at 925-0342 or 1-800-257-4747.

CAMC/WVU Health Sciences Center - Charleston

January 11 - "Laparoscopic Cholecystectomy," 7 a.m., WVU Auditorium

January 12 - "Laparoscopic Cholecystectomy," 6:30 a.m., Women & Children's Hospital Boardroom

January 28 - "The Current Treatment and Management of the Acute Myocardial Infarction," 12:30 p.m., WVU Bldg. Room 2014

February 3 - "The Tenth Midwest Cardiovascular Conference," 6 p.m., Snowshoe Mountain Ski Resort

Ohio Valley Medical Center - Wheeling

January 9 - "Pathological Changes in Asthma and their Significance," Herbert Mansmann, M.D., 8:00 a.m.

January 23 - "Unknown Primary," Thomas Przybysz, M.D., 8 a.m.

January 30 - TBA

Harrison County Medical Society - Clarksburg

February 7 - "Alphabets of Hepatitis," John Thomas, M.D., DeCarDe, Inc., 5 p.m.

CME Outreach Programs

Key to Sponsors

★ WVU Health Sciences Center, Morgantown

☐ CAMC (•)/WVU Health Sciences Center-Charleston (△)

(Check locally for additional information)

Fairmont ★ Fairmont Clinic, January 16, 1 p.m., "Methicillin Resistant Staph Aureus Infections," Rashida Khakoo, M.D.

Fairmont ★ Fairmont General Hospital, January 8, 7:30 p.m., "Vertigo," Stephen Wetmore, M.D.

Man ☐ Man Appalachian Hospital, January 15, 7 p.m., "Diabetic Retinopathy," Mark Hatfield, M.D.

Montgomery ☐ Montgomery General Hospital, February 6, noon, "The Use and Abuse of Benzodiazepines: Atwan, Xanax, etc.," David Walker, M.D.

New Martinsville ★ Wetzel County Hospital, January 10, 11:30 a.m., "Peptic Esophagitis," Ronald Gaskins, M.D.

Parkersburg ★ Camden Clark Memorial Hospital

January 9, 7 a.m., "Identifying the Troubled Child," John Kelley, M.D.

January 16, 7:30 a.m., "Exercise and the Diabetic Patient," Irma Ullrich, M.D.

January 23, 7 a.m., "Anorexia/Bulimia Eating Disorders," John Vanin, M.D.

January 30, 7 a.m., "Problems in the Elderly," Eric Rankin. M.D.

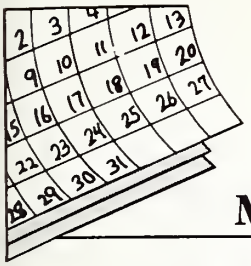
Point Pleasant ☐ Pleasant Valley Hospital, January 24, noon, "Diabetes Update," Steve Grubb, M.D. and Peg Adams, RNC.

Ripley ☐ Jackson General Hospital, January 11, noon, "What's New in Hip Arthritis," Frederic Pollock, M.D.

Ronceverte ☐ Humana Hospital - Greenbrier Valley, January 16, 1 p.m., "Neonatal Resusitation," Stefan Maxwell, M.D.

Spencer ☐ Roane General Hospital, January 15, 12:30 p.m., "What's New in Hip Arthritis," Frederic Pollock, M.D.

Waynesburg, Pa. ★ Greene County Memorial Hospital, January 22, 7 p.m., "Rational Guide to Salt and Water Problems," Michael Sorkin, M.D.



Medical Meetings

January

17-19—Annual Refresher Course and Scientific Meeting of the American Academy of Pain Medicine, Miami.
18-20—American Laryngological, Rhinological, and Otologic Society, Inc., Santa Barbara, Cal.
18-20—Diagnostic Dilemmas in Cardiology, Southern Medical Association, Cancun, Mexico.
24-26-Neurological Society of the Virginias, The Greenbrier, White Sulphur Springs, WV.
26-27—How to Get Started in Medical Practice, Southern Medical Association, Charleston, S.C.
28-30—Cardiopulmonary Rehabilitation Symposium: Status '91, Center for Exercise Science, Gainesville, Fla.

February

8-9—Dermatology for the Non-Dermatologist, Ohio State University, Columbus.
8-10—8th National Interim Postgraduate Course of the American Society for Gastrointestinal Endoscopy, Coronado, Cal.
16-18—American Association for Geriatric Psychiatry, Ft. Lauderdale, Fla.
20—How to Manage a More Profitable Practice, Southern Medical Association, Orlando, Fla.
22-23—Infectious Disease 1991: Current Problems, Ohio State University, Columbus.
28-March 2—Advances in Pulmonary and Critical Care Medicine, Southern Medical Association, Montego Bay, Jamaica.
28-March 2—What Works: Bridging the Gaps for America's Children, Children's Defense Fund, Washington, D.C.
28-March 3—The Ninth Annual International Symposium on Man and His Environment in Health and Disease, The American Environmental Health Foundation, Dallas.

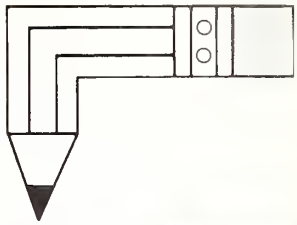
March

1-2—The 34th Annual Postgraduate Symposium in Ophthalmology: Current Concepts in Ocular Inflammation," Ohio State University, Columbus.
7-8—High Risk Obstetrics: The Problem Pregnancy, Ohio State University, Columbus.
8-9—Second Annual Ophthalmology Alumni Weekend WVU Department of Ophthalmology, Morgantown.

For More Information . . .

Contact The Journal for additional information about most of the above meetings. Call (304) 925-0342.

Poetry Corner



Jake

A young and friendly doctor
Came to town to live one day
And started treating patients
In a kind and gentle way.

They gave him their affection
And there grew a loyalty
Between this family doctor
And his patient family.

For years he dedicated
All his days and nights to treat
The illnesses they brought him
While he kept their names discreet.

For babies he delivered,
And for others till their death,
He cared for all their problems
From their first to final breath.

He rose among his colleagues
In the state society
To assume the job of president
And served them skillfully.

The years went by quite swiftly
As he reached a time and day
When an illness overtook him
And removed him from the play.

But from those he had befriended
He received a heaping share
Of attention, time and skill,
And their tender, loving care.

Dedicated to
J.C. "Jake" Huffman, M.D.,
my good friend and colleague,
who is a former president of
the West Virginia State Medical
Association.

E. Leon Linger, M.D.

Change

From the moment of our birth,
The time we take first breath,
Life is a continuum of change,
Right to the instant of death.

Change in the way we act
And change in the way we look;
Gradual change, progressive
change,
As turning pages of a book.

Change that cannot be denied,
Change that one cannot delay,
Change in the way we speak and
think,
And in the way we work and play.

We live, we grow, we learn,
And resist it though we try,
We cannot stop the change we see,
For to stop it is to die.

E. Leon Linger, M.D.

Please address your submissions for Poetry Corner to: Stephen D. Ward, M.D., Editor, West Virginia Medical Journal, Box 4106, Charleston, WV 25364.

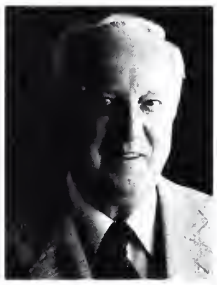
"Our Concern Be Peace Of Mind."

Theocritus, 230 B.C.

Morgan E. Scott, M.D.

Neil P. Dubner, M.D.

Arthur E. Kelley, M.D.


Basil E. Roebuck, M.D.

Don L. Weston, M.D.

Orren LeRoyce Royal, M.D.

G. Paul Hlusko, M.D.

D. Wilfred Abse, M.D.

Ronald L. Myers, M.D.

Hal G. Gillespie, M.D.

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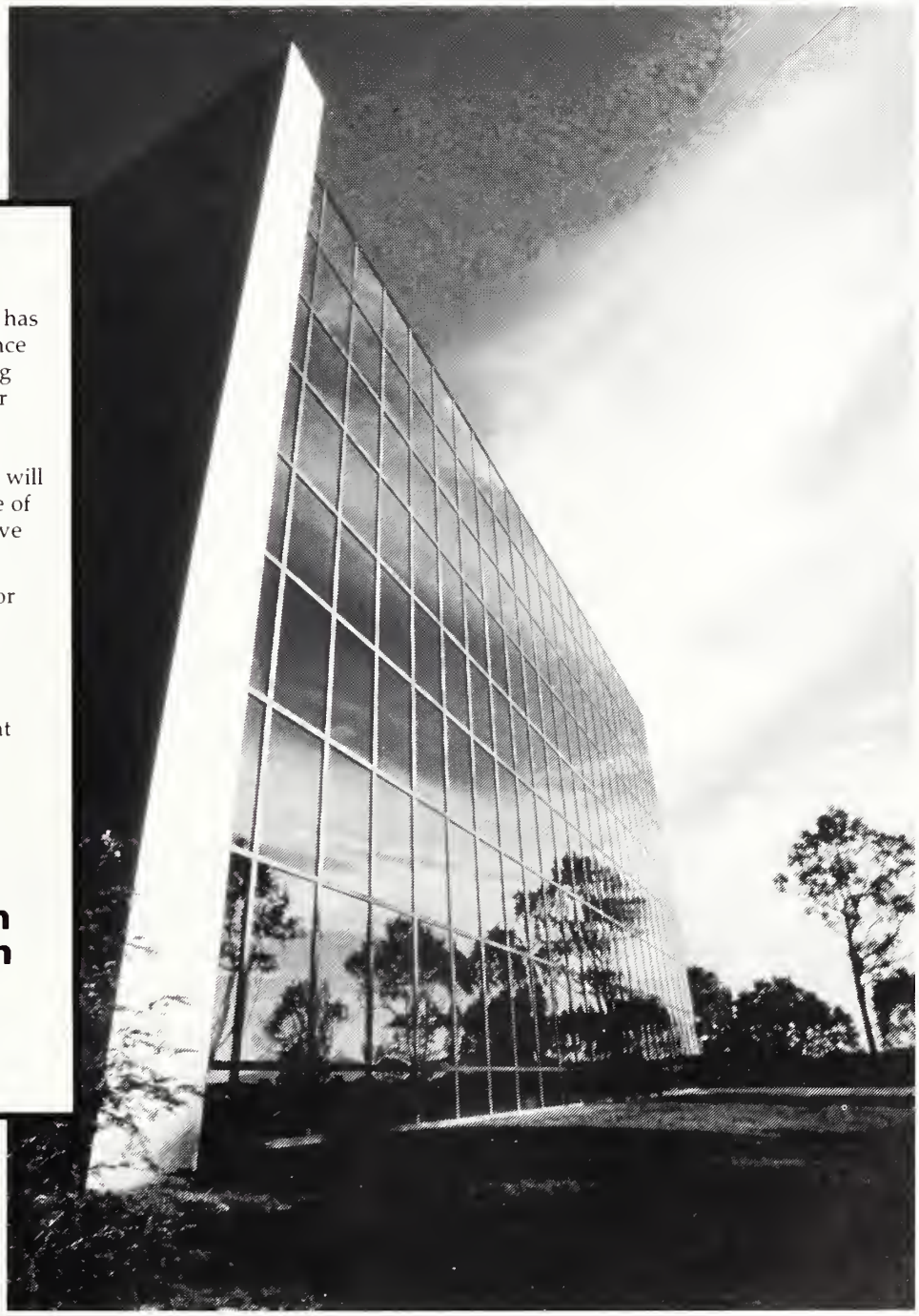

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WEST VIRGINIA UNIVERSITY HEALTH SCIENCES CENTER

Compiled from material furnished by the West Virginia University Health Sciences Center News Service, Morgantown.

New Perspectives Given on Breast Reconstruction

Ricardo Baroudi, M.D., a renown Brazilian plastic surgeon and visiting professor of the International Society of Anesthetic Plastic Surgery, spoke at WVU in October to update health care professionals and students on the physiological and psychological issues of breast reconstruction.

"I want to stress how important it is for plastic surgeons to have an empathetic attitude toward women who want breast reconstruction, and to help them select a technique that is both conservative and effective for them," Dr. Baroudi stated. "It's very important in all aspects, whether the patients have had cancer or not, "for physicians to offer interested women the best and most appropriate surgical options available to correct their physical imperfections," he added.

Dr. Julio Hochberg, associate professor of plastic surgery in the WVU Department of Surgery, elaborated by explaining that in the past decade, plastic or reconstructive surgeons have been able to increase the number of options for patients who have undergone cancer surgery, or to women whose self image can be improved with surgery.

"WVU surgeons primarily employ three types of procedures for breast reconstruction," Dr. Hochberg said. One method uses tissue expanders and the other two procedures involve transplantation of the patient's own tissue. Even though donor tissue cannot yet be used, it may be possible in the next 20 years," he added.

Neurologist's Study Gives Insight on Nerve Gas

Dr. Ludwig Gutmann of the WVU School of Medicine has studied the effects of organophosphate pesticides on dozens of patients at a German medical center and says that only a few hundred poison gas exposures would severely tax hospital resources in Europe and the United States.

Dr. Gutmann, who recently briefed U.S. Army doctors in Frankfurt on this subject, has visited the University of Mainz Medical Center regularly for several years to study patients who have attempted suicide by swallowing pesticides. The pesticides, including malathion and parathion, are chemically similar to so-called "nerve gases" known to be stockpiled by the Iraqi Army. Suicide attempts with insecticides, though practically unknown in the U.S., are fairly common in the rest of the world, according to Dr. Gutmann.

"The University of Mainz sees six to 10 patients a year who have ingested large doses of organophosphate compounds," Dr. Gutmann explained. "Patients who suffer heavy exposures to organophosphates can develop a number of symptoms, including mental changes ranging from irritability, through weird dreams, up to coma; profuse sweating and excessive secretions; and paralysis.

"The paralysis often includes the muscles used in breathing, and many patients must be placed on ventilators for several days. I'm not sure how many ventilators would be available for a large number of casualties," Dr. Gutmann added.

Dr. Gutmann's research at WVU and the University of Mainz has centered on the synapses, connections between nerve fibers and other cells.

Grant Awards Assist Four Research Projects

Research is now underway at WVU on four new projects thanks to grants from Pharmacia, Inc.; West Virginia Health Care Cost Review Authority; the National Science Foundation and the Department of Health and Human Services.

A clinical evaluation involving the "Nicotine Inhaler (Nicohaler) vs. Placebo in Smoking Cessation," is being conducted with a grant of $365,000 from Pharmacia, Inc. Elbert D. Glover, Ph.D., director of the Mary Babb Randolph Tobacco Research Center, is the study's principal investigator.

Data entry and time-sharing services for analysis of UB-82 data will be provided with a grant of $140,389 from the West Virginia Health Care Cost Review Authority. Cecil Polland, manager, health services research, is the study's principal investigator.

The National Science Foundation's grant of $97,500 is continuing studies of how peptides, which are found in thyroid nerves, act to regulate the blood flow to the thyroid gland and its secretion of hormones. This is the second year of a three-year project which is entitled, "Neuropeptide Control of Thyroid Secretion and Blood Flow." Dr. George Hedge, associate dean of the WVU School of Medicine, is the study's principal investigator.

West Virginia University has also received a grant of $23,470 from the Department of Health and Human Services to provide financial assistance for disadvantaged students pursuing health professions. Dr. John Jones, vice president for health sciences, is the principal investigator for this study.

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MU School Of Medicine News

MARSHALL UNIVERSITY

Compiled from material furnished by the Office of University Relations, Marshall University.

EPSCoR Funds Boost Cell Research

Cell biology researchers at Marshall University School of Medicine believe they now have the resources to determine the structure and function of a blood-borne substance that may be involved in the development of hypertension.

Marshall is sharing a large two-year grant with West Virginia University which is funded jointly by the state and the federal government. The National Science Foundation's prestigious Experimental Program to Stimulate Competitive Research (EPSCoR) has awarded the two universities a total of $1.2 million. The state's matching grant for the first year is $1.2 million.

Marshall researchers are developing state-of-the-art cell biology facilities featuring three large, specialized laboratories and nearly $500,000 in new equipment purchased with EPSCoR funds, according to Dr. Gary Wright, chairman of the Department of Physiology and cell biology project director. The new labs, located in Marshall's Medical Education Building at the Huntington VA Medical Center, will support research and training that may open the door to improved treatments for high blood pressure, he said.

Possibilities for advances in cell biology go far beyond the hypertension study itself, Dr. Wright pointed out. One focus of the study is the mechanisms regulating calcium levels in blood vessel cells. "Calcium is central to so many cellular processes, such as hormone regulation and the contractile function," he said. "This research may provide very fundamental information."

Several years ago, Dr. Wright and fellow Marshall researcher William McCumbee discovered a blood-borne compound, which they have tentatively identified as a peptide, associated with hypertension. Once the EPSCoR team determines the compound's structure, they will be well on the way to synthesizing it.

"New opportunities will open up when we can make the compound ourselves," Dr. Wright said. "If we can make it, we can get the compound in the quantities we need for a variety of studies examining its biological properties. Then, other investigators can begin to study it and we will be able to develop knowledge more widely and quickly."

Other important advances in cell study techniques are possible as well. Research team members are developing a way to culture isolated blood vessels. "If we can remove a blood vessel and keep it in culture for days or weeks without altering its fundamental properties," Dr. Wright explained, "we can open up all kinds of research avenues."

Marshall's project also has a strong educational component. Brief, intensive training sessions will involve 10 to 15 faculty members and students to rapidly expand the university's pool of expertise in cell biology. Plans also call for including faculty from other colleges and high school teachers in workshops. The laboratories themselves will be made available to any interested investigator in the state.

The Marshall project has important implications for economic development in the state, according to Dr. Gary Rankin, an associate dean at Marshall and a member of EPSCoR's state advisory board. "Biotechnology is one of the fastest growing medical industries," Dr. Rankin said. "If we develop a pool of people trained in cell biology, hopefully we will attract those industries here."

Principal researchers on Marshall's EPSCoR team are Dr. Wright; Dr. Edwin C. Johnson, assistant professor of physiology; Dr. Mitchell L. Berk, associate professor of anatomy; Dr. Vernon E. Reichenbecher, Jr., associate professor of biochemistry; and Dr. Donald A. Primerano, assistant professor in microbiology. Administrative director of the project is Dr. Albert G. Moat, chairman of the microbiology department.

Larsen Awarded Grant for Microbiology Studies

Dr. Bryan Larsen of the Marshall University School of Medicine has received a $90,000 grant through Johnson & Johnson's highly competitive "Focused Giving Program" for his research in microbiology.

Several Nobel Prize winners were among the 36 researchers receiving grants this year through the Johnson & Johnson program. Grants are approved for only one out of every eight proposals submitted, according to the company.

In addition to the three-year Focused Giving Program grant, Johnson & Johnson has awarded Dr. Larsen a $28,000, six-month contract for related research.

Dr. Larsen, a professor in the Departments of Obstetrics and Gynecology and Microbiology, is studying the immune system's response to a certain toxin produced in yeast infections. In his laboratory at MU, Dr. Larsen discovered that the toxin, called gliotoxin, suppresses the immune response. His Focused Giving grant will be used to further the study of gliotoxin's effect on the infection-fighting abilities of white blood cells. Dr. Larsen will also investigate how gliotoxin affects the infected individual's ability to produce antibodies.

"I believe that this research will not only help us in obtaining a fuller understanding of how this microorganism causes disease, but will also give us some new insight into the immune response itself," Dr. Larsen explained.

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County Societies

McDowell

The annual Christmas party of the McDowell County Medical Society was held on December 8 at Raymond's Restaurant in Welch.

Recommendations were unanimously accepted for the following new officers for 1991: Alexander Herland, M.D., president and alternate; Eugene Kao, M.D., vice president; Charles Michaelis, M.D., secretary-treasurer; Lewis Vega, M.D., delegate; and David Carr, M.D., alternate.

D. Barnes, M.D., D. Phillip, M.D., B. Homily, M.D. and B. Omaji, M.D., were accepted for membership after the Society members passed a motion changing the requirement in their bylaws that members must be registered at the County Clerk's office. This change in the bylaws was made after the doctors read a letter from the local prosecuting attorney to the director of the Department of Health which questioned whether or not it was still a legal requirement that local physicians register in the county's record book.

A motion was also passed that a donation of up to $250 be made to the Legislation Investigation Fund Effort (L.I.F.E.) for West Virginians.

South Branch

A financial report and membership dues statements were distributed at the annual Christmas dinner party for the South Branch Medical Society.

This dinner party was held at the Highlands Restaurant in Petersburg.

Obituary

Dr. Karl A. Dillinger, 75, of Clarksburg, died October 23 in United Hospital Center following a brief illness.

Born in Peru, Ill., Dr. Dillinger was a graduate of West Virginia Wesleyan and the University of Maryland School of Medicine. He began his general medical practice in Weston in the early 1940s and worked in partnership with Dr. John Lawson. In the 1950s, he opened his private surgical practice in Clarksburg.

A veteran of WWII, Dr. Dillinger served with the U.S. Marine Corps. He was a member of the Harrison County Medical Society and a Fellow of the American College of Surgeons.

Surviving are his wife, Carole Ladwig Dillinger; one son, Karl A. Dillinger II, Neptune City, N.J.; one niece, Karla Merrifield and a nephew, James Merrifield.

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References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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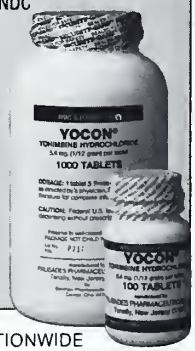

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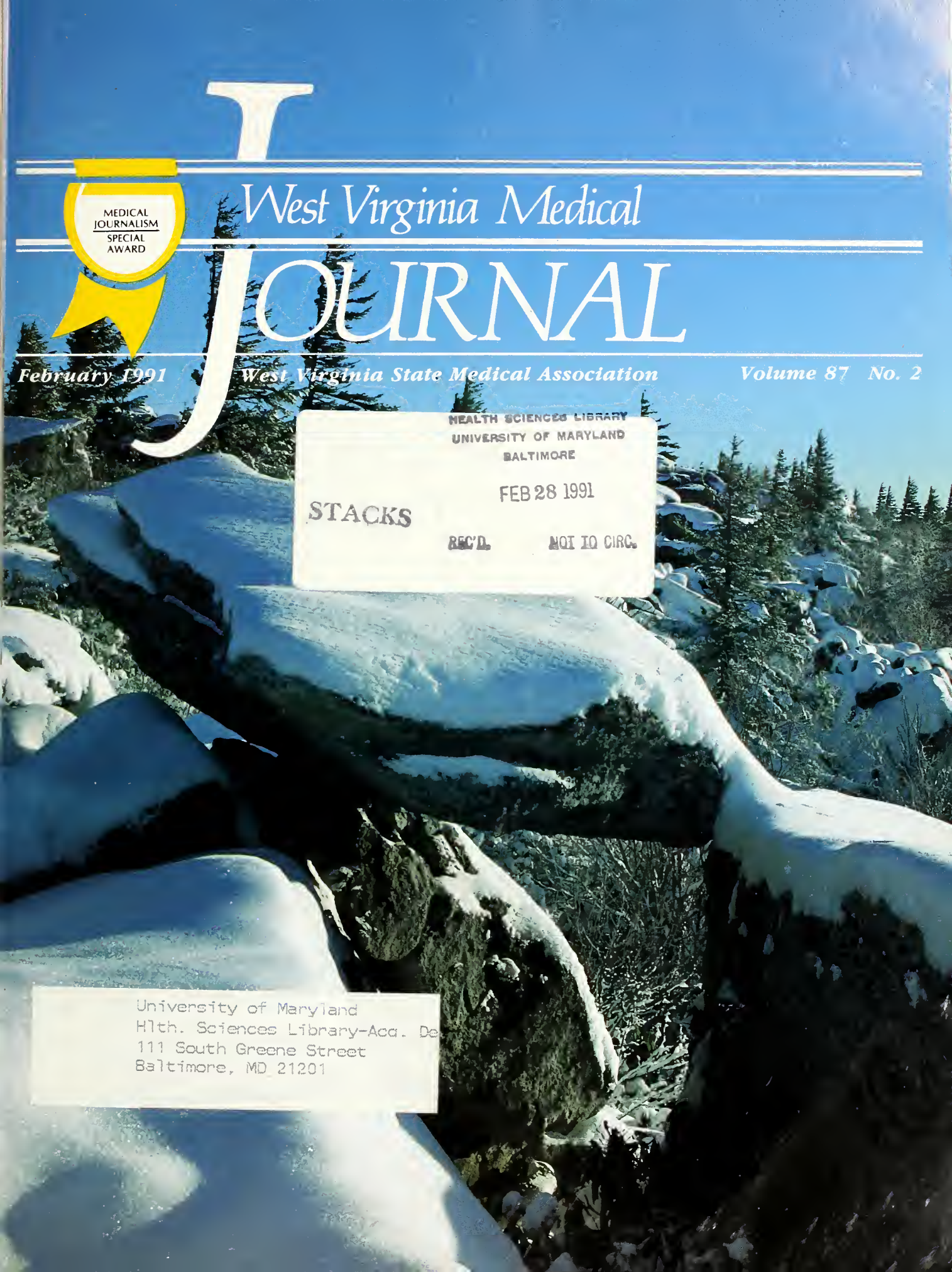

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A wintry day at Dolly Sods in Tucker County. Photo courtesy *Stephen J. Shaluta Jr., West Virginia Department of Commerce.*

The Effects of Liability Issues on the Practice of Medicine

IRENE LOUDA, M.H.A.;
ELIZABETH McCOLEMAN, M.H.A.;
CHERYL DEMETRAKIS, M.H.A;
OLLIE JACKSON, M.H.A.;
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Ohio University, Athens, Ohio

Editor's Note: *The following article is an abbreviated and edited version of a research paper compiled by the above Ohio University students for members of the Ohio County Medical Society.*

Introduction

Five Ohio University graduate students conducted a study of liability issues in Ohio County, West Virginia during the summer of 1990. This research developed out of a previous report done by two of these students for the Ohio County Medical Society regarding liability issues and tort reform recommendations for West Virginia (1).

Information for the study was obtained from a questionnaire created by the graduate students which was mailed to all of the members of the Ohio County Medical Society. The findings of this questionnaire reveal the impact that liability issues are having on these physicians and will hopefully contribute to the current body of knowledge in West Virginia concerning this subject.

Historical Review

There is a growing national debate about the real cost of liability insurance, with estimates of this "hidden tax" costing the economy at least $80 billion a year (2).

Some experts feel liability costs are hampering U.S. competitiveness both abroad and at home and are contributing to the rising cost of living. Even this country's international trade deficit has been negatively influenced by liability costs. American companies must attempt to compete against foreign countries who do not have to operate under legal structures which promote friction, uncertainty and invite litigation (1).

During the Reagan era, U.S. health care policies emphasized competition to control costs. These market-driven policies have not controlled the public's costs, but have produced increased frustration, alienation, and anger in the medical profession (3).

The problem of excessive litigation, and its associated liability costs has been developing for several years and has had the effect of stifling overall productivity and competitiveness. A heightened public awareness of liability, an increased willingness to sue and the increase of huge settlements caused insurance premiums to skyrocket. The Rand Corporation's Institute for Civil Justice (4), refers to the above developments as "high stakes" litigation, characterized by both a substantial increase in claim frequency and an explosive growth in the average magnitude of awards.

Peter Huber (5) cites a number of examples of the extraordinary growth of the financial costs of tort litigation. For instance, damage claims against cities have doubled between 1982 and 1986. The probability that a plaintiff will win his suit has dramatically increased from 20 percent to 30 percent in the 1960s, to more than 50 percent in the 1980s. The average judgment awarded rose fivefold, from an inflation adjusted $50,000 in the 1960s to more than $250,000 in the 1980s.

The health care industry has been particularly affected by the present system of high stakes litigation which has negatively influenced both the way medicine is practiced and the accessibility to care. The cost of U.S. health services now represents 11 percent of the country's Gross National Product (4).

Some experts have questioned whether our system of tort liability genuinely results in improved diagnosis and treatment. High premium and malpractice risks have influenced the physician's specialty choices. Harris (6) reports that physicians have even added procedures because of the risk of a lawsuit.

These deterent effects of professional liability have dramatically driven up the cost of medical care. The high cost of premiums to insure against

TABLE 1
Comparison of Commercial Automobile Insurance Premiums — West Virginia, Virginia, Pennsylvania, Ohio and Kentucky

COMMUNITY	SERVICE-USE PICK-UP Under 10,000 lbs. GVW	COMMERCIAL TRUCK 35,000 lbs. GVW	EXTRA-HEAVY TRUCK Over 45,000 lbs. GVW
HUNTINGTON, WV	1,113	2,254	3,327
IRONTON, OH	687	1,390	2,052
ASHLAND, KY	323	653	976
LEWISBURG, WV	641	1,298	1,915
COVINGTON, VA	501	1,015	1,489
MORGANTOWN, WV	764	1,546	2,283
UNIONTOWN, PA	586	1,247	1,813
WHEELING, WV	872	1,766	2,503
WASHINGTON, PA	657	1,399	2,033
ST. CLAIRSVILLE, OH	671	1,298	1,915
PARKERSBURG, WV	711	1,438	2,125
MARIETTA, OH	687	1,390	2,052
BLUEFIELD, WV	684	1,386	2,045
BLUEFIELD, VA	565	1,327	1,958

malpractice suits has made physicians into proponents of reforms that would change the way malpractice litigation is conducted and awards are determined.

A recent Johns Hopkins University survey of Maryland physicians in specialty practices of family or general practice, obstetrics and gynecology (OB/GYN), and internal medicine demonstrated the following outcomes (7):

A) Physicians (51 percent) reported making some type of practice change, reflecting two strategies:

1. risk reduction, for example the increased use of tests;
2. risk avoidance, for example cutting back on accepting high-risk patients

B) Fees increased for patient services

C) OB/GYN's were more likely to report practice changes

D) Litigation experiences did not predict practice changes.

West Virginia has been particularly beset with problems brought about by liability litigation. A recent comparison shows liability insurance costs are significantly higher in West Virginia than in surrounding states. Total liability costs in West Virginia have more than doubled between the years of 1983 and 1988, with an average increase of $60 million per year (8). See Tables I and II for a comparison of liability insurance costs.

The state of West Virginia ranks 37th for physicians per capita in the United States. The American Medical Association reported only 157 West Virginia physicians for every 100,000 residents, well below the national average of 189 for every 100,000 residents. This problem is exacerbated by the fact that the state is losing physicians. Eighty seven physicians left West Virginia to practice elsewhere during the first nine months of 1989 (9).

The loss of physicians in West Virginia is felt to be tied to a number of problems, particularly business costs which make West Virginia an unattractive place to practice medicine. The problem of practicing medicine in a state having uncertainty and instability in the cost of medical malpractice insurance does little to promote retention of physicians. All liability premiums doubled from 1983 through 1988, with medical liability premiums for West Virginia increasing 169 percent. This means a significantly higher premium for West Virginia physicians compared with the premiums paid by physicians in Pennsylvania, Ohio, Kentucky, and Virginia. A vivid example of this is brought home by the fact that "only in West Virginia are OB/GYN insurance premiums as high as those for neurosurgeons" (8).

TABLE 2
Comparison of Selected Insurance Rates - West Virginia and Virginia

TYPES OF BUSINESS	WEST VIRGINIA	VIRGINIA
ANTIQUE STORES	3.30	1.51
APARTMENT BUILDINGS	73.01	40.72
BOWLING LANES	10.02	5.66
FLORISTS	2.83	1.29
FURNITURE SHOPS	2.36	1.61
GIFT SHOPS	2.83	1.29
MEDICAL OFFICES	94.04	44.99
YMCA	239.70	159.46

Figure 1—Questionnaire mailed to all members of the Ohio County Medical Society in June 1990

QUESTIONNAIRE

Demographics

Sex _____ Female _____ Male
Age Group _____ 25-35 _____ 36-45 _____ 46-55 _____ 56-65 _____66-over
Status _____ Full Time _____ Part Time _____ Retired
Type of Practice _____ Solo _____ Group (Independent) _____ Hospital Based
_____ Organization (HMO, Clinics)
Years in Practice _____ 0-2 _____ 3-5 _____ 6-10 _____ 11-15 _____ 16-20 _____20 +
Is Your Base Practice in West Virginia? _____
Years in Practice in West Virginia
_____ 0-2 _____ 3-5 _____ 6-10 _____ 11-15 _____ 16-20 _____20 +

Type of Practice

Family Practice	___	Dermatology	___
OB/GYN	___	Cardiology	___
Anesthesia	___	Orthopedics	___
Emergency	___	Internal Medicine	___
Surgical Sub Specialty	___	General Surgery	___
Ophthalmology	___	Other	___

1. Have your services changed in the past five years? ___ Yes ___ No
   A. Have you eliminated services/procedures? ___ Yes ___ No
   B. Have you added services/procedures? ___ Yes ___ No
2. Have you considered leaving the state to practice? ___ Yes ___ No
3. Have you considered leaving the practice of medicine permanently? ___ Yes ___ No
4. Does the cost of general liability insurance concern you? ___ Yes ___ No
5. Does the cost of medical liability insurance concern you? ___ Yes ___ No
6. Who is responsible for your medical liability insurance? ___ Self ___ Corp
7. Has your liability insurance increased disproportionately to your other business expenses? ___ Yes ___ No
8. Are you in favor of legislative tort reform? ___ Yes ___ No
9. Would you support a coalition advocating tort reform? ___ Yes ___ No
10. Would you like additional information concerning physician involvment? ___ Yes ___ No
11. What concerns you most about medical liability? (Please Choose One)
    Cost of Insurance _____
    Fear of Litigation _____

Ohio County Research Results

To gain insight into the role that liability issues were having on the members of the Ohio County Medical Society, the questionnaire

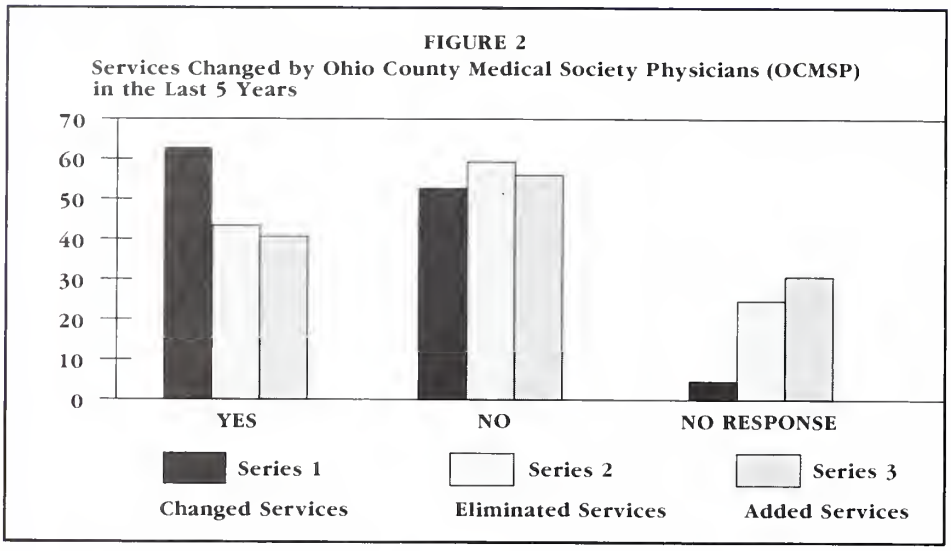

FIGURE 2
Services Changed by Ohio County Medical Society Physicians (OCMSP) in the Last 5 Years

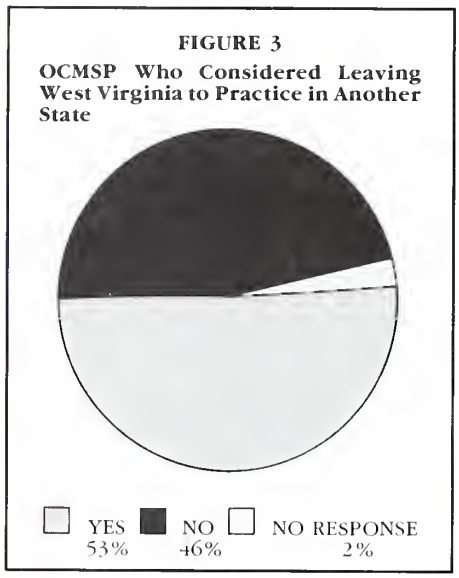

FIGURE 3
OCMSP Who Considered Leaving West Virginia to Practice in Another State

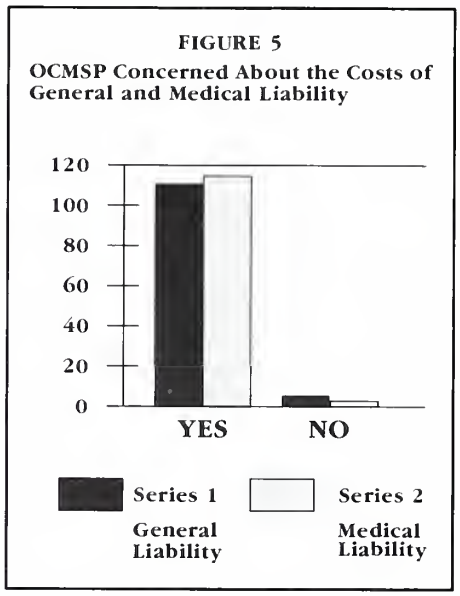

FIGURE 5
OCMSP Concerned About the Costs of General and Medical Liability

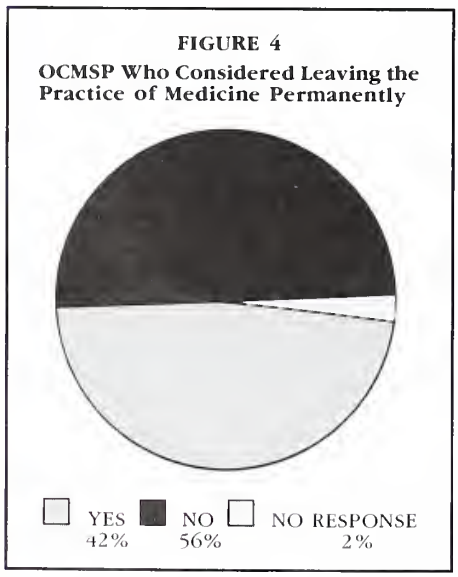

FIGURE 4
OCMSP Who Considered Leaving the Practice of Medicine Permanently

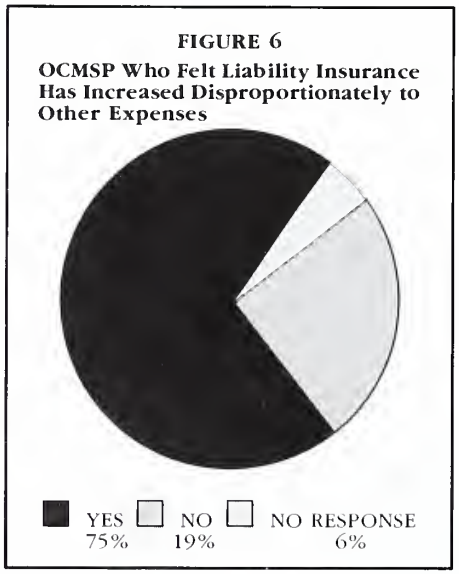

FIGURE 6
OCMSP Who Felt Liability Insurance Has Increased Disproportionately to Other Expenses

in Figure 1 was mailed to each of these physicians. The data collection and the first-class mailing for this study was done by the Society, which absorbed the entire expense of this project. The questionnaire was accompanied by a cover letter from James L. Comerci, M.D., president of the Ohio County Medical Society.

There was no follow-up to ensure questionnaire return. Results were based on the total 206 surveys mailed less any returned or undelivered. Eighteen questionnaires received after the closure date were not considered in this data.

The return rate of 116 surveys was excellent for the target population. Ninety-one percent of those responding were males between the ages of 36-55 (54 percent). Of the physicians participating in the study, 44 (38 percent) were in a group practice, 43 (37 percent) had their own practice; 20 (17.2 percent) were hospital-based physicians; 7 (6 percent) worked for private organizations and 2 (2 percent) did not specify their type of practice. Those responding included 102 full-time physicians, 5 physicians working part time and 4 retired physicians.

Of the 116 physicians responding, 53 percent reported making service changes in the past five years. Overall, of these same physicians, 37 percent eliminated services or procedures while 36 percent added services or procedures. Many of the respondents answered "yes" to both (Figure 2).

In addition, 53 percent considered leaving the state of West Virginia to practice medicine (Figure 3), while 42 percent contemplated leaving the practice of medicine permanently (Figure 4). The findings further indicated that 64 percent of internal medicine specialists reported a change in their services as compared to 50 percent of OB/GYN specialists.

The study also showed that OB/GYN physicians are more concerned with the fear of litigation than the cost of liability insurance. Nearly 88 percent of OB/GYN practitioners reported their main concern to be the fear of litigation.

Coincidental findings from the survey reveal a nearly unanimous concern for the cost of both general and medical liability (Figure 5). Three quarters of physician respondents felt liability insurance had increased disproportionately to other business expenses (Figure 6). One hundred and fifteen physicians responded in favor of legislative tort reform (Figure 7), while 113 indicated support for a coalition advocating tort reform (Figure 8).

Dicussion

The data collected supports the assumption that Ohio County physicians' service changes were brought about by the influence of liability issues on their practice of medicine. These physician service changes reflect the services/procedures eliminated and the services/products added.

OB/GYN physicians did not report practice changes at the same rate as internal medicine physicians. These findings did not support the recent Johns Hopkins University survey which reported that OB/GYNs were more likely to report practice changes. The results could be due to the small number of respondents in this specialty population (8), which makes it difficult to infer to a larger population of OB/GYN physicians. Nor can this study reflect the attitudes or opinions of disenchanted physicians who have already made their exodus from the state of West Virginia.

Overall, 72 respondent physicians agreed that fear of litigation concerned them more than the cost of liability insurance (Figure 9). These findings prevailed even though 45 percent stated that their malpractice premium was paid by self rather than a corporation (Figure 10). This is a strong indication that physicians want tort reform.

In addition, 42 percent of physicians indicated that they had considered leaving the practice of medicine permanently. Among these physicians, choosing an elective retirement rather than an alternate career may be a factor. There was no information available to discriminate this possibility.

The data substantiates the fact that liability issues are influencing the practice of medicine in Ohio County, West Virginia and that OB/GYN physicians are more concerned with the fear of litigation than the cost of liability insurance. The data does not show that OB/GYN physicians are more likely to report practice changes than internal medicine physicians. The findings raise many more questions which suggest the development of a revised questionnaire. The way in which physician practice changes are influenced by liability issues is an important topic for further study.

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FIGURE 7
OCMSP Favoring Tort Reform

FIGURE 8
OCMSP Favoring A Coalition Advocating Tort Reform

FIGURE 9
Medical Liability Concerns of OCMSP

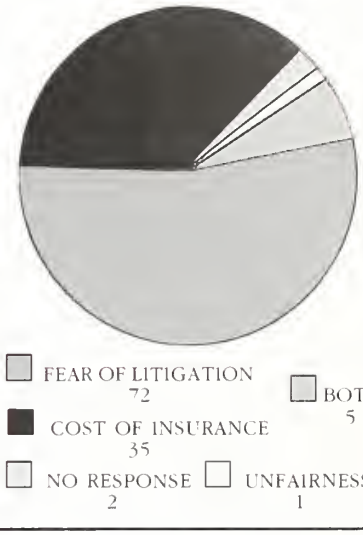
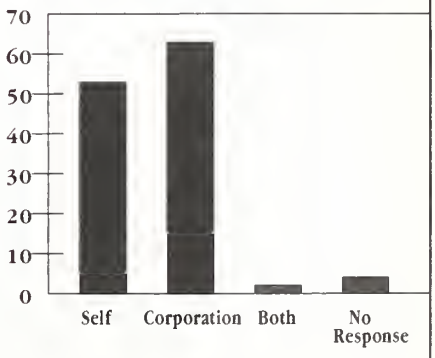


FIGURE 10
Parties Responsible for OCMSP's Malpractice Insurance



Cricopharyngeal Myotomy with Diverticulopexy for Zenker's Diverticulum

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Abstract

Prolonged cricopharyngeal dysfunction due to various causes can lead to severe dysphagia, aspiration, pneumonia, debilitation and subsequent pharyngoesophageal (Zenker's) diverticulum. This paper reports the successful use of cricopharyngeal myotomy with diverticulopexy for management of huge Zenker's diverticulum on five high-risk patients. The advantages of this method are immediate swallowing, short hospitalization, and avoidance of serious complication.

Introduction

Since Ludlow's (1) description of pharyngoesophageal diverticulum in 1769, methods of management of Zenker's diverticulum have been reported in the literature, however, criteria for method selection have not been specific. Konowitz and Biller (2) in 1989 addressed the rationale for various treatment of Zenker's diverticulum especially in the poor-risk patients. They claimed that cricopharyngeal myotomy with diverticulopexy is the preferred treatment of Zenker's diverticulum in the elderly and debilitated patients. By using this method, complication was obviated, hospitalization shortened and swallowing was soon restored.

Materials and Methods

Between 1969 and 1990, 37 patients underwent surgical management for Zenker's diverticulum at the Eye and Ear Clinic of Charleston and Charleston Area Medical Center. Twenty-two patients had a one-stage cricopharyngeal myotomy with diverticulectomy, 10 patients had cricopharyngeal myotomy alone for diverticulum of less that 3 cm (Figure 1 and 2) and five patients had cricopharyngeal myotomy with diverticulopexy starting in 1988. Ages for all patients ranged from 45 to 87. Average age for the diverticulopexy group was 75. There were 25 men and 12 women, all had preoperative symptoms of dysphagia to solids and regurgitation and some had aspiration, recurrent pneumonia and debilitation. Diagnosis of Zenker's diverticulum was established by barium esophagram with videofluoroscopy. Upper GI series were also done to exclude concomitant hiatal hernia or gastroesophageal reflux (3) which were found in 40 percent of our cases.

Surgical Technique

Ninety percent of these cases were done under local anesthesia with intravenous sedation. With the patient's neck in a right

Figure 1. Barium swallow showing a 2.5 cm Zenker's diverticulum.

Figure 2. Post cricopharyngeal myotomy barium swallow showed resolution of Zenker's diverticulum.

lateroextension, the skin incision was made along the anterior margin of the left sternocleidomastoid muscle from the thyroid level to the second tracheal ring. The carotid sheath was retracted laterally after displacement of the thyroid lobe anteromedially and the anterior omohyoid muscle inferiorly.

Using the inferior border of the thyroid cartilage and the previously inserted esophageal stent (#7 endotracheal tube) as guides, exposure of the diverticular neck was accomplished by transection of the cricopharyngeal muscle along it posterolateral border with the aid of an operating loupe (2.5X). Inadvertent injury to the recurrent nerve was avoided by staying clear of the cricoarytenoid joint. Use of a #7 endotracheal tube as an esophageal stent prevents mucosal overexcision when diverticulectomy had been required. The myotomy was carried 1.5 cm above and beyond the cricopharyngeus until esophageal mucosa and diverticular base were exposed. The diverticulum was upended without tension and anchored to the prevertebral fascia with a couple of interrupted sutures. The incision was closed in layers over a suction drain after irrigation with hydrogen peroxide and normal saline solutions.

These patients were fed orally six hours postoperatively when fully reactive and discharged 1-2 days after the operation. Drains were removed 24 hours following the operation.

Case Illustration

An 86-year-old white woman was transferred to the Eye and Ear Clinic from another hospital because of difficulty swallowing solid foods and liquids. She was recovering from recurrent aspiration pneumonia. She lost 60 pounds in six months due to a gradual and progressive upper pharyngeal dysphagia that had been noted for five years. Examination disclosed a poorly nourished patient with copious oral secretions and intermittent productive coughing. Both vocal cords were closing adequately. She was receiving intravenous fluids and antibiotics. Barium swallow showed an 8 cm pharyngoesophageal diverticulum without laryngo-tracheal penetration (Figure 3).

Under local anesthesia with sedation, the patient underwent a cricopharyngeal myotomy with diverticulopexy. She was fed orally the day after surgery, when the postoperative barium swallow demonstrated improved flow of barium into the esophagus without tracheal aspiration (Figure 4). She was discharged from the hospital on the second postoperative day. She has been followed for one year with improved swallowing and absence of pneumonia.

Results

All five patients who had cricopharyngeal myotomy with diverticulopexy obtained relief of symptoms of dysphagia, aspiration, regurgitation and pneumonia. Except for food coming up when stooping after meals, all patients had no other complaints and complications. The longest follow-up period is two years.

Discussion

Diverticulopexy (sac suspension) was first proposed by Schmid in 1912 and subsequently used by Hill (1) in 1917. Belsey (4) in 1966 reported a large series on the efficacy of diverticulopexy. Cricopharyngeal myotomy alone or in combination with diverticular procedures have been advocated since studies have shown that cricopharyngeal dysfunction is the key to the pathogenesis of the diverticulum (5). Increased intraluminal pressure of the cricopharynx produces a pulsion diverticulum through Killian's triangle, a weakened area between the transverse cricopharyngeus muscle inferiorly and the oblique fibers of the inferior constrictor muscle superiorly. Thus, Zukerbraun and Bahna (6) used myotomy alone in seven patients with sac ranging from 3 cm to 8 cm. All patients were fed orally on the first postoperative day.

Ellis et al (7) recommended cricopharyngeal myotomy alone for sac of less than 5 cm and excision with myotomy for larger than 5 cm. Hieber (8) advocated cricopharyngeal myotomy alone for less than 2 cm sac and adding diverticulopexy

Figure 3. Preoperative barium swallow showing an 8 cm Zenker's diverticulum.

Figure 4. Post cricopharyngeal myotomy with diverticulopexy barium swallow showing reduced diverticulum.

for larger sacs. Kinley (9) and Gagic (10) used myotomy only for less than 4 cm diverticula. Gullane (11) et al compared patients treated with diverticulectomy and myotomy, diverticulopexy and myotomy, and myotomy alone, and concluded that myotomy is the most important step in all of these procedures. Orringer (12) emphasized that cricopharyngeal myotomy should be done to restore swallowing and to prevent recurrence, although Payne and King (13) had 90 percent success rate in more than 800 patients with Zenker's diverticulum who underwent diverticulectomy alone. Orringer also suggested that success without myotomy could be attributed to inadvertent transection of the cricopharyngeus muscle fibers during exposure of the neck to diverticulum.

Impressive results of cricopharyngeal myotomy with diverticulopexy have been reported by Belsey (4), Duranceau (14), Hiebert (8) and Hollinger (15). Despite these results, Hollinger and Schild preferred Dohlman's (16) endoscopic cricopharyngeal myotomy for the debilitated patients. Trible (17) cautioned the limitations of the endoscopic technique such as a small pouch for instrumentation, previous surgery, poor exposure and mediastinitis as a fatal complication in 5 percent of cases. According to Konowitz and Biller (2), potential short-comings of circopharyngeal myotomy with diverticulopexy are missing a diverticular carcinoma (0.4 percent incidence) and prolapse of the sac resulting in symptom recurrence.

Review of our cases and the literature discloses specific criteria in the management of Zenker's diverticulum, namely:

1. cricopharyngeal myotomy alone for diverticulum of less than 3 cm.
2. cricopharyngeal myotomy with diverticulectomy over 3 cm in healthy patients.
3. cricopharyngeal myotomy with diverticulopexy for the dibilitated and elderly.
4. endoscopic diverticulotomy should be done with extreme caution because of potential mediastinitis.

Conclusion

The advantages of myotomy with diverticulopexy are prompt relief of dysphagia, short hospitalization, prevention of salivary fistula and its long-term results.

Acknowledgements

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Preliminary Results of Skin Cancer Screening in West Virginia

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Abstract

Although skin cancer screening is theoretically of value, its effectiveness has not been firmly established because few studies have systematically followed persons with a positive screen to obtain pathologically confirmed diagnoses. From the 799 persons screened at Charleston Area Medical Center in 1988 and 1989, 153 screenees with suspected skin cancer, dysplastic nevi, and congenital nevi were followed to determine their final diagnosis.

Follow-up was done by letter and telephone calls to both the individuals who screened positive and their treating physicians. Eighty-four (54 percent) then sought medical attention as a result of letters and calls. Thirty-one basal cell carcinomas, three squamous cell carcinomas, three dysplastic nevi, two melanomas, and one congenital nevus were pathologically confirmed.

The predictive value positive of the screenings was 32 percent to 60 percent for non-melanoma skin cancer, 9 percent to 25 percent for dysplastic nevi, and 15 percent for melanoma. This study suggests that post-screening follow-up of those with suspected premalignant and malignant skin lesions is feasible and should be encouraged so that more definitive evaluation and treatment can potentially be performed and skin cancer screenings more accurately assessed.

Introduction

The rising incidence of skin cancer is a growing public health concern. Basal cell and squamous cell carcinoma together account for greater than 500,000 cases of skin cancer each year. These types are in general easily treated when diagnosed early. However, an estimated 28,000 new cases of melanoma will be diagnosed in this country in 1990, and about 6,300 Americans will die of this disease (1). Melanoma represents 2 percent - 3 percent of all cancers by incidence and 1 percent - 2 percent of all cancer deaths.

Skin cancer/melanoma has several features that make it amenable to a screening program:

1) Skin cancer has the highest incidence among all cancers.

2) The skin is the most accessible organ to examine and treat.

3) The screening exam consists of simple visual inspection, which is brief, non-invasive, inexpensive, and regarded as reliable.

4) The treatment of melanoma at an early stage strongly correlates with improved survival rates (2).

However, the effectiveness of skin cancer screening has not been firmly established because few studies have systematically followed subjects with a positive screen to determine their eventual pathologic diagnosis.

The purpose of this report is to describe the results of skin cancer screening performed at Charleston Area Medical Center (CAMC) in 1988 and 1989 and to provide information about the income of those who had a positive screen.

Materials and Methods

At the time of the screen, participants were asked to fill out an American Academy of Dermatology (AAD) designed registration and report form which supplied the following information:

1) name, address, age, and sex;
2) name of personal dermatologist or family physician;
3) history of skin cancer;
4) family history of skin cancer;
5) history of X-ray treatment for acne or other skin conditions;
6) use of sunscreen, and
7) permission for screening and follow-up.

The screening dermatologist visually examined the skin and recorded the results of the screen (normal vs. suspicious for cancer or precancerous lesion - i.e. melanoma, basal cell carcinoma, squamous cell carcinoma, dysplastic nevus, congenital nevus, actinic keratosis, or other) on the AAD form. Of the 799 participants, 520 (65 percent) consented to have a complete examination and 240 (30 percent) opted for a partial examination (i.e. of sun-exposed areas only). The type of examination in 40 (5 percent) of these individuals was not recorded. No biopsies or procedures were done. Persons with normal screens were told that no further diagnostic procedures or treatment was necessary. Those with lesions suspicious for cancer of precancerous lesions were asked to see their own dermatologist or personal physician for diagnostic procedures or treatment. For individuals without a dermatologist or personal physician, names of local physicians were offered.

Approximately one year after the screen, letters were sent to all clinically-positive participants requesting details about their follow-up and results of treatment. These persons were asked whether they had seen a doctor in follow-up, the results of the biopsy, if performed; and the nature of treatment, if any. Letters requesting

TABLE I: Age Distribution of Those Screened for Skin Cancer in 1988 and 1989

Age	Number
0—9	13 (1.7%)
10—19	22 (2.8%)
20—30	41 (5%)
31—40	105 (13%)
41—50	117 (14.5%)
51—60	158 (20%)
61—70	223 (28%)
Over—70	120 (15%)

TABLE II: Positive Screenees Followed in the 1988 and 1989 CAMC—AAD Sponsored Skin Cancer Screening

Suspected Diagnosis		Screened	No. Followed (%)	Biopsy Proven
Melanoma		13	13 (100%)	2
Squamous Cell Carcinoma	non melanoma skin cancer	7	5 (71%)	3
Basal Cell Carcinoma	non melanoma skin cancer	99	53 (54%)	31
Dysplastic Nevus		33	12 (36%)	3
Congenital Nevus		1	1 (100%)	1
Total		**153**	**84 (54%)**	**40 (26%)**

similar information were also sent to the patients' treating physicians. Self-addressed stamped envelopes were included to encourage a response.

Telephone calls were made to the individuals with positive screens or physicians who had not returned information about follow-up or whose information did not give satisfactory information about ultimate triage. Some clinically-positive screened persons were diagnosed, managed, or treated without a biopsy. In such cases, the treating physicians' diagnosis was regarded as the final diagnosis.

From the follow-up results, the numbers of true-positives and false-positives for each of the disease categories was determined and a predictive value positive for screening was then derived. The predictive value of a positive test is the proportion of true positive among all who have positive test results. The range of predictive values of a positive screen accounts for including or excluding those lost to follow-up. The sensitivity (true-positive/true-positive + false-negative x 100 percent) and specifity (true-negative/true-negative + false-negative x 100 percent) could not be determined because persons with a negative screen were not followed.

Results

Five volunteer dermatologists screened 799 people for melanoma/skin cancer in 1988 and 1989. Of these, 524 were female (65 percent) and 275 (35 percent) were male. The age distribution of the persons screened is shown in Table I. The majority (618 or 77 percent) were over age 40. Fourteen percent (117) had a prior history of skin cancer, 31 percent had a family history of skin cancer, and 6 percent (48) had a history of X-ray treatment for acne. Only 224 of these individuals (28 percent) claimed to use sunscreen regularly.

Fifty-one percent of 417 of the people studied were thought to have an abnormal examination and were asked to see their dermatologist or family physician for follow-up. Basal cell carcinoma was the suspected diagnosis in 99 cases, dyplastic nevus in 33, malignant melanoma in 13, squamous cell carcinoma in 7, and congenital nevus in 1 (See Table II). In addition, 254 individuals had suspected actinic keratoses.

Follow-up efforts were concentrated on the 153 persons studied with suspected melanoma, basal cell carcinoma, squamous cell carcinoma, dysplastic nevi, and congenital nevi. Of these, follow-up information was obtained on 84 (54 percent). Table II shows that successful follow-up by suspected diagnosis ranged from 36 percent to 100 percent. Of the 69 (46 percent) who could not be followed, 41 (27 percent) never saw a dermatologist or family physician and 28 (19 percent) did not respond to repeated inquiries. Thus, 54 percent sought medical attention and 27 percent chose not to do so, giving a total of 81 percent who reported their action in response to a positive screen. It is possible that many of the 19 percent who could not be reached also sought definitive medical treatment.

Table II shows the number of confirmed cancers and dysplastic nevi. The two pathologically confirmed melanomas were superficial spreading melanomas both Clark level II. Thirty-one basal cell carcinomas, three squamous cell carcinomas, three dysplastic nevi, and one congenital nevus were pathologically confirmed.

The predictive value positive was 32 percent to 60 percent for non-melanoma skin cancer, 9 percent to 25 percent for dysplastic nevi, and 15 percent for melanoma.

Discussion

Since screening itself confers no health benefit, those with a positive screen must obtain subsequent care for definitive diagnosis and treatment. Through letters and telephone calls, follow-up information was obtained on 81 percent of the individuals with positive screens. Pathologically confirmed follow-up information was available for 26 percent of these patients (or 47 percent of all those who followed-up with a physician). These numbers would have increased had those who were screened negative or those with suspected actinic keratosis been followed. The follow-up rates by suspected diagnosis range between 36 percent and 100 percent. Despite a recommendation to do so, 27 percent of the persons with positive screens did not see a physician.

TABLE III: Published Studies of Skin Cancer Screening in the General Population

Author	Year	Total No. of Screens	Number with Suspected Skin Cancer				Number with Suspected Pre Cancerous Lesions				Number of Pathologically Confirmed Malignant and Premalignant Lesions						
			BCC	SCC	MM	Total	AK	DN	CN	Total	BCC	SCC	MM	AK	DN	CN	Total
Weary[3]	1971	548	23	4	—	27	68	8	—	74	—	—	—	—	—	—	—
Lynch et al[4]	1973	3040	51	*	—	51	—	—	—	—	—	—	—	—	—	—	—
Kanof[5]	1974	418	16	5	1	22	82	14	—	96	—	—	—	—	—	—	—
Zagula-[6] Malley et al	1974	978	33	10	—	43	159	—	—	159	5	1	—	1	—	—	—
Loeffel and[7] Watson	1975	605	49	11	—	60	88	—	—	88	—	—	—	—	—	—	—
Biro and[8] Price	1978	232	30	2	1	33	29	—	—	29	—	—	—	—	—	—	—
Rigel et al[9]	1986	2239	288	52	14	354	454	144	—	598	—	—	14	—	—	—	14
Olsen et al[10]	1987	983	100	7	28	135	221	—	—	221	—	—	—	—	—	—	—
Field[11]	1987	6340	506	36	30	572	1293	—	—	1293	—	—	—	—	—	—	—
Fixler[12]	1987	1675	111	4	5	120	288	39	—	327	—	—	—	—	—	—	—
Long[13]	1988	200	28	2	—	30	30	14	—	44	—	—	—	—	—	—	—
Koh et al[14]	1990	2560	210	26	6	262	288	170	27	485	54	7	9	—	27	3	100
Jubelirer et al (present study)	1990	799	99	7	13	119	254	33	1	288	31	3	2	—	3	1	40
TOTAL		20,617	1544	166	118	1828	3255	422	28	3805	90	11	25	1	30	4	154

BCC—Basal Cell Carcinoma
SCC—Squamous Cell Carcinoma
MM—Malignant Melanoma
AK—Actinic Keratoses
DN—Dysplastic Nevi
CN—Congenital Nevi
* All Skin Cancers

One may speculate that many persons who failed to comply either had no regular physician or dermatologist or did not know how to obtain proper treatment. The fear of diagnosis of cancer or of diagnostic procedures may have prompted others to avoid follow-up.

At least 13 published studies have examined melanoma/skin cancer screening in the general population (see Table III) (3-14). Of the 20,617 persons screened, skin cancer was suspected in 1,828 (9 percent). Eighty-four percent (1,544) of these presumptive cancers were basal cell carcinoma were basal cell carcinoma, 9 percent (166) squamous cell carcinoma, and 7 percent (118) malignant melanoma. Precancerous lesions (3,705) were suspected in 18 percent of all persons screened. Eight-eight percent (3,255) of these were actinic keratoses, 11 percent (422) dysplastic nevi, and 1 percent (28) congenital nevi.

Although all of these studies establish the feasibility and potential for skin cancer screening, none adequately evaluate its validity in terms of sensitivity and specificity. Only three studies (6, 9, 14) in addition to the present one, give members of pathologically-confirmed skin cancers and none systematically followed more than a few cases to assess their eventual disease outcome.

The sensitivity and specificity of skin cancer screening can vary considerably, depending on the person performing the screen and the population being screened. For example, screeners may differ in their ability to provide a high-quality standard examination. Physicians lacking specialized training in dermatology would be expected to have greater difficulty in evaluating skin lesions (15, 16, 17). In one study (15) in which skin photographs were shown to dermatologists and non-dermatologists, five of the six photographs of malignant melanoma were correctly identified by 69 percent of the dermatologists but only by 12 percent of the non-dermatologists. Both of the two photographs of dysplastic nevi were recognized by most of the dermatologists but only by 31 percent of the non-dermatologists. The inability to perform a complete skin examination on many of these screenees may also limit the sensitivity and specificity. Riegel et al (9) have shown that there is greater than a six-fold increased chance of detecting malignant melanoma when complete cutaneous examinations are

performed as opposed to when partial examinations are performed.

The sensitivity of screening also depends on characteristics of the individuals screened. For example, if the screened population has not previously received health care, many cases of skin cancer may be picked up by screening and the sensitivity will be high. If, however, the more obvious cases have been diagnosed during previous office or clinic visits, the sensitivity will be lower.

Although screening is of value in detecting basal cell and squamous cell carcinoma, its principal benefit lies in discovering early stage melanoma since its treatment correlates with improved survival rates. This disease is relatively uncommon in the general population (lifetime risk of 0.7 percent) (18). Only 7 percent of presumptive cancers noted in the published literature were melanomas. Of these, only 20 percent were pathologically confirmed (0.12 percent of all those screened).

Since over 99 percent of patients who would be examined under routine screening would never have malignant melanoma, it is important to consider the adverse effects of screening such as the increased expense and inconvenience of physician's office visits and anxiety generated by a false-positive exam. In light of these concerns, some experts have suggested restricting screening to high-risk groups. Those include white persons with dysplastic nevi, a positive family history, fair complexion and light skin, and a changing mole.

Despite its limitations, screening is important because it prompts many of those screened to seek treatment earlier and provides the potential for the primary prevention of skin cancer through public education. Most of the people screened at CAMC were instructed in appropriate sunlight protection measures and were made aware of the need to seek attention as early as possible for lesions which have not healed or may be bleeding. With no cure for metastic melanoma in sight and with the continued high incidence of non-melanoma skin cancer, it would appear that the public could be spared much pain, expense, and death through an effective skin cancer screening program. However, more data is needed to address the as yet unanswered question of whether such a program can reduce morbidity and mortality.

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Medical Grand Rounds

West Virginia University Health Sciences Center

Edited by Irma H. Ullrich, M.D., Professor of Medicine

Acute Post-Streptococcal Glomerulonephritis

Discussant:
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Abstract

Acute glomerulonephristis is characterized by the presence of hematuria, proteinuria and edema, and often hypertension and acute renal failure. Acute post-streptococcal glomerulonephritis is the prototypic disease of acute glomerulonephritis. It is seen after both streptococcal pharyngeal and skin infections with a latency period from infection to presentation of 7-14 days and 14-21 days respectively.

Approximately 90 percent of post-streptococcal glomerulonephritis occurs in young children. The diagnosis is made by supporting evidence of recent streptococcal infection, a positive ASO-titer or Anti-DNAase B titer, with associated hypocomplementemia. The disease is self-limited and generally requires only supportive therapy with resolution occurring over a period of weeks to months. There are generally no permanent sequelae in children. Adults may have a higher incidence of hypertension and chronic renal failure as a result of post-streptococcal glomerulonephritis.

Case History

J.M. is a 20-year-old white male who came to the emergency room complaining of blood in his urine, mild leg edema and facial puffiness in the antecedent 3-4 days. He denied any fever, chills, recent sore throat, honeycombed skin lesions, hydrocarbon exposure, hemoptysis, arthralgias, myalgias, sun sensitivity, intraveneous drug use, aphthous ulcers, purpura, previous hematuria, stones, or upper respiratory symptoms involving the sinuses. His past and family medical histories were remarkable and he was taking no medication.

On exam he was a pleasant, disheveled male in no apparent distress. His blood pressure was 160/100, pulse 110, respirations were 24, temperature 98.6. He had no pharyngeal erythema and a regular S1 and S2 with a 1/6 systolic ejection murmur. Jugular venous pressure was 8 cms, and hepatojugular reflux was present. There was 1+ ankle edema. His lungs were clear and the abdomen had no hepatosplenomegaly. His skin has three 2x5 cm. lesions on his left lower extremity with "scabs." There was no surrounding erythema or purulence noted.

Admission laboratory electrolytes were normal. The BUN was 40 mg/dl and creatinine 2.1 mg/dl; albumin 3.1 gm/dl; WBC 8,000 (with 70 pmn's, 18 lymphs, 2 mono's); and hemoglobin 12.1 gms; platelet count 335,000. His urinalysis was remarkable for 3+ blood and 3+ protein, greater than 100 RBC's per high-powered field. No RBC casts were observed. His ASO titer was negative, streptozyme negative, anti-DNAase B positive at a titer of 1:640, C3 was 8 mg/dl (normal 80-140 mg/dl) and C4 was 20 mg/dl (normal 15-50 mg/dl). All other serology was negative.

The first portion of this discussion will center around acute glomerulonephritis; and the second portion will deal more specifically with acute post streptococcal GN.

Classification

Acute glomerulonephritis or AGN is defined as the sudden appearance of hematuria, proteinuria, red blood cell casts often associated with edema. A sub-division of AGN is rapidly progressive glomerular nephritis or RPGN, which is defined as a rapidly decreasing glomerular filtration rate with renal failure occurring in weeks to months. This is often associated with 50 percent - 70 percent crescent formation on pathologic examination.

The forms of acute glomerulonephritis are subdivided by the serum complement level, more specifically C3 (1). Those acute glomerulonephritides associated with a low serum complement level and associated with systemic disease include systemic lupus erythematosus, subacute bacterial endocarditis, "shunt" nephritis and cryoglobulinemia. Acute glomerulonephritis with low complement which are primary renal diseases include post streptococcal glomerulonephritis and membranoproliferative glomerulonephritis both type I and type II.

The acute glomerulonephritides associated with normal serum complement are also broken down into systemic diseases with renal involvement and primary renal disease. Diseases found within the systemic category are polyarteritis nodosa, hypersensitivity vasculitis, Wegener's granulomatosis, Henoch-Schonlein purpura, Goodpasture's syndrome and visceral abscesses. Those that are primarily renal diseases include IgA nephropathy, idiopathic RPGN, anti-glomerular basement membrane disease, immune complex disease and renal vasculitides with negative immunofluorescence.

Initial Evaluation

The initial workup of a patient suspected of having acute glomerulonephritis involves urinalysis, serum creatinine, 24-hour urinary protein and creatinine clearance, C3, C4, and CH 50 levels, ANA and DNA binding, glomerular basement membrane antibodies, cryoglobulins, hepatitis B surface

antigen, ASO titer, anti-DNAase B titer, and an audiogram. Blood cultures may be helpful particularly in suspected cases of subacute bacterial endocarditis. Most of these tests are self explanatory. The hepatitis B surface antigen is checked because of its association with concurrent polyarteritis nodosa. The audiogram may be used to assure that a person does not have Alport's Syndrome which on occasion can be confused for an acute glomerulonephritis if the time course and prior history are not available.

The urinalysis is quite helpful in determining the presence of acute glomerulonephritis and in particular its association with hematuria. In normal individuals, there are approximately 1,500 RBC's excreted into the urine per minute. This correlates to 500,000 to 2,000,000 RBC's per day. On a random urine sample, anywhere from 0-2 RBC's per high-powered field are anticipated. In pathologic states, there are greater than 2-5 RBC's per high-powered field.

A characteristic of hematuria related to glomerulonephritis or "upper tract disease" is the presence of a dysmorphic red blood cell (2). When red cells are lost into the tubular space and pass through the loop of Henle or the medullary collecting duct, the marked osmotic changes that occur tend to crenate the red blood cells. Dysmorphic RBC's seen by phase contrast microscopy or under the light microscope are therefore diagnostic of upper tract disease. The lack of dysmorphic RBC's however does not preclude upper tract disease.

The red blood cell cast is diagnostic of acute glomerulonephritis. The best sample of urine to obtain looking for casts is the early-morning urine because it tends to be of high osmotic concentration and also acidic. Both of these factors are important in preserving cellular casts. In alkaline or in very dilute urine, the previously-formed casts will dissolve.

Hematuria typically is persistent but on rare occasions may be intermittent. Hematuria may be microscopic or gross. Red cells enter Bowman's space through gaps in the glomerular basement membrane. Further definition of this is not known at present in most cases.

In normal individuals, there should be less than 500 mg of protein excreted per day. In AGN, usually there is between 500 mg to 3 gm of protein excreted per day. Typically, this is albumin. This amount of proteinuria with the other classic findings of red cells and red cell casts gives the diagnosis of "nephritic syndrome." On rare occasions, the patient may have more than 3 gms of albumin per day excreted into the urine. This amount of proteinuria associated with the syndrome of acute glomerular nephritis has been tagged nephritic-nephrotic.

The mechanisms of proteinuria are somewhat better understood. The normal pore size through which molecules may pass through the glomerular capillary wall is between 5 and 5½ nm. Under normal circumstances, there is a size barrier such that molecules greater than 5½ nm do not pass through the gaps. The gaps also possess charge-selective properties. Most of the material lining the gaps are anionic residues which are highly charged including sialic acid, heparin sulfate proteoglycan and free carboxyl residues. This high frequency of anionic charges repulses molecules that are negatively charged. Albumin is such a molecule and at 3.6 mm it should be able to pass through the glomerular capillary, but because of the negative charges it is repulsed. Under normal circumstances it does not enter the urine.

In pathologic disease states in which the anionic charges are lost in the capillary wall, albumin then enters the urinary space, i.e. Nil lesion. In acute glomerulonephritis, there seem to be several other processes occurring. Capillary destruction and endothelial cell proliferation decrease the surface area for filtration and decrease the capillary ultrafiltration coefficient. This would not only decrease GFR but tends to decrease overall pore density. In this state, a new population of pores with an average radius of 8-10 nm emerges. Approximately 1 percent - 3 percent of total ultrafiltration will occur across these pores. As this occurs, there is the appearance of charged molecules such as albumin or larger neutral-charged molecules such as IgG. In this instance, hetero-porosity is seen and this large-pore shunt pathway resolves when the disease abates (3).

The formation of edema is primarily the result of abnormal sodium and water retention by the kidney. With the subsequent expansion of plasma volume and often accompanying systemic hypertension, there is increased capillary hydrostatic pressure favoring formation of edema. This is augmented by the tendency toward hypoalbuminemia with accompanying decreased capillary oncotic pressure. The mechanisms by which primary sodium reabsorption occurs within the kidney are not well known. It is not entirely explained by the diminishment in GFR or increased proximal tubular reabsorption. It appears that there is augmented distal reabsorption of sodium chloride and water which leads to the expansion of plasma volume (4). This abstraction of sodium and water from the urine in AGN will also be reflected as a fractional excretion of sodium of less than 1 percent.

In a recent study by Dr. Rodriguez-Iturbe (5), circulating atrial natriuretic factor (ANF) levels were measured in individuals with post-strep GN. ANF was markedly elevated and higher than that seen in normal individuals who were on a high sodium diet (300 mEq/day). In acute post-strep GN, there should be sufficient ANF to induce a sodium and water diuresis if the underlying resistance were not present. Five to 10 days after admission, the ANF levels fell markedly when the patients started to diurese.

Acute Post-Streptococcal Glomerulonephritis

Acute post streptococcal glomerulonephritis (APSGN) was first described in Florence and Vienna after scarlet fever epidemics in the early 1700s (6). This predated Bright's description in the early 1800s (7).

In 1905, Reichel (8) confirmed the microscopic pathology of GN after an episode of scarlet fever and in

1929, beta hemolytic strep pharyngeal infection was noted to antedate APSGN (9). Then, in 1940, beta hemolytic strep skin infections were noted to precede APSGN (10). Although acute post streptococcal GN is the prototypic AGN disease, acute glomerulonephritis however, is not equivalent to APSGN. Post streptococcal GN occurs in epidemics and sporadically. Both clinical and subclinical presentations have been noted.

The peak incidence varies depending upon the climate. In temperate climates, APSGN occurs in the winter and spring after pharyngeal infections. In subtropics and tropical areas, a summer and fall incidence is noted to be higher after pyoderma.

Over 90 percent of individuals affected with post streptococcal GN are in the age range of 2-12 years. A five percent incidence is noted in those less than 2 years old and in those over 40. There tends to be a male predominance for those who have clinical presentations of APSGN. However, considering all cases of clinical and subclinical APSGN, there is equal gender distribution between male and females.

Sporadic forms of APSGN are most likely seen in the United States presently. There is an actual decrease in its incidence due to improved health care. Epidemic acute post streptococcal GN, however, is still prevalent. It is found in those areas which are closed communities, rural and city slums where hygiene tends to be poor such as the Red Lake epidemic in the 1960s (10). There is also an endemo-epidemic area found in Trinidad and Venezuela where there are cycles of APSGN every 5-7 years (11).

Figure 1
Findings on presentation in APSGN *

Clinical	**Percentage of Patients**
Hematuria	100% (1/3 macroscopic)
Edema	89%
Hypertension	82%
Proteinuria	80%
Oliguria	50%
General malaise, weakness, anorexia	55%
Nausea, vomiting	15%
Laboratory	
Serum C_3 <100 mg/dl	89%
Cryoglobulinemia	72%
Serum Rheumatoid Factor ≥1:32	43%
Serum Creatinine ≥2mg.dl	25%

* Modified from [16]

Pathogenesis

The pathogenesis of APSGN is dependent on infection with a nephritogenic strep organism. These are commonly defined by M serotypes. M serotypes associated with pharyngeal infections include 1, 2, 4, 12, 18, 25, 49, 55, 57 and 60. APSGN associated with pyoderma is seen with types 49, 55, 57 and 60.

There have also been several non-M typeable infections thought to be responsible for APSGN. Not only is the right organism important but also the location of infection (12). M serotype 49 has been associated with a 5 percent incidence of APSGN after pharyngitis but a 25 percent incidence after pyoderma. The M protein is not likely to be the nephritogenic antigen. Several studies have been conducted in which convalescent serum has been taken from individuals afflicted with APSGN and fluorescein tagged. The tagged serum is then placed on a renal biopsy of another individual with APSGN. Positive immuno-fluorescence has been documented despite the second individual being affected with a different M serotype.

There are three antigens currently under laboratory investigation as a nephritic antigen (10,13,14) and two are likely to be the same antigen. The one that is best defined is endostreptosin and water soluble pre-absorbing antigen. This particular antigen has been found to have a molecular weight of 43-50 daltons. When this antigen is added to fluorescein tagged convalescent serum, there is subsequently no staining seen in a renal biopsy of another patient with early post streptococcal GN.

Mechanisms

The mechanisms involved in development of acute post strep GN are likely multi-factorial. There appears to be obvious humoral involvement and likely in-situ antigen antibody formation. The endostreptosin antigen has been shown to imbed itself in the glomerular basement membrane (15). Antibody subsequently interacts with the antigen.

There are also circulating immune complexes evidenced by a relatively high incidence of cryoglobulins (16). Autoimmune phenomenona may play a contributory or modulating role in the disease process. The streptococcal bacteria frequently possess neuraminidase activity. Streptococcal neuraminidase removes sialic acid moieties from IgG and renders native IgG as foreign. Immunoglobulin is subsequently made in reaction to it, most frequently IgM. This likely accounts for the relatively frequent incidence of rhematoid activity in APSGN (10).

IgG has also been noted to bind to FC receptors on streptococcal filaments. In this process, IgG will again become a foreign antigen with subsequent antibody production. Cellular pathogenic mechanisms are very poorly understood. In all probability, macrophages play a role. Experiments with antimacrophage serum given to afflicted individuals will decrease the amount of proteinuria (17). T-cells are also likely to be involved in modulating the disease process. Cyclosporin-A given to individuals will improve

the disease (18). This cyclosporin-A effect is probably due to the diminished production of interleukin-2 from stimulated T-cells. Any genetic involvement in the disease process is unknown at this time.

Clinical Presentation

How patients present with acute post streptococcal GN is best seen in the accompanying diagram (Figure 1). It should be noted that only 40 percent of individuals have all of the criteria of edema, hematuria, hypertension and oliguria which define acute GN. In addition, it should be noted that of all nephritogenic streptococcal infections, only 15 percent will develop post streptococcal GN. Over 90 percent will be subclinical presentations of acute GN; 9.6 percent will have the acute nephritic syndrome as defined; .4 percent will have a predominant nephrotic syndrome; and less than .1 percent will have a presentation as RPGN.

There is a time lag between the actual streptococcal infection and subsequent development of glomerulonephritis. This latency period is between 7-10 days after pharyngitis and 14-21 days after a pyogenic infection.

Diagnosis

Most often the diagnosis is made on clinical grounds with supporting laboratory data. Positive ASO titers, anti-DNAase B titers or streptozymes are only indicative of recent streptococcal infections. There must also be accompanying evidence of hypocomplementemia before this can be truly implicated. In most instances, biopsy is not required to formalize the diagnosis, particularly in young children. One can wait and watch for normalization of the complement level. If the complement level does not normalize within six weeks to two months or if there is abnormal renal function on presentation, consideration should be given to biopsy for confirmation of the diagnosis.

On light microscopy, the glomerular tuft is noted to be markedly expanded. There are increased numbers of mesangial and endothelial cells seen. Classically, there are infiltrating PMNs, macrophages and plasma cells which support the diagnosis of exudative proliferative glomerular nephritis (Figure 2). Crescents are often seen but rarely of sufficient number to make the diagnosis of RPGN. Subepithelial humps are also found on occasion and are synonymous with the diagnosis of acute post streptococcal GN.

Immunofluorescence on biopsies has three classic appearances (19). The first is a starry sky pattern which appears early. IgG, IgM and C3 are found scattered throughout the biopsy and more classically in the loop area. Later, in progression, there will be a mesangial pattern seen by 4-6 weeks in which there is often only C3 remaining to stain in the mesangium. The IgG and IgM enter the mesangium but leave relatively early. A third type is known as the garland pattern because it has massive quantities of IgG and IgM and C3 surrounding the capillary loops in the subepithelial space, giving the appearance of a garland. On electron microscopy, subendothelial deposits are rarely seen. More classically, subepithelial humps are observed and these tend to correlate both with the garland pattern and clinically with massive proteinuria (20).

Therapy

Penicillin is given to those individuals who are deemed to have persistent streptococcal infection. Penicillin will not prevent APSGN in an individual already infected with the organism. Prophylactic treatment particularly of siblings may be warranted in situations in which there appears to be epidemic or an endemo-epidemic outbreak of streptococcal infection.

The hypertension and oliguria that frequently accompany post streptococcal GN are treated most effectively with water and salt restriction. Many individuals benefit from the addition of loop diuretics either furoseamide or bumetanide (Bumex®) to induce a diuresis. Other antihypertensive agents which have been used with good success include the standard hydralazine in young children and more recently angiotension converting enzyme (ACE) inhibitors. ACE inhibitors are effective in spite of low plasma renin activity from volume expansion. Renal failure rarely progresses to the point where dialysis is needed. If this should occur, usually only one or two treatments are necessary.

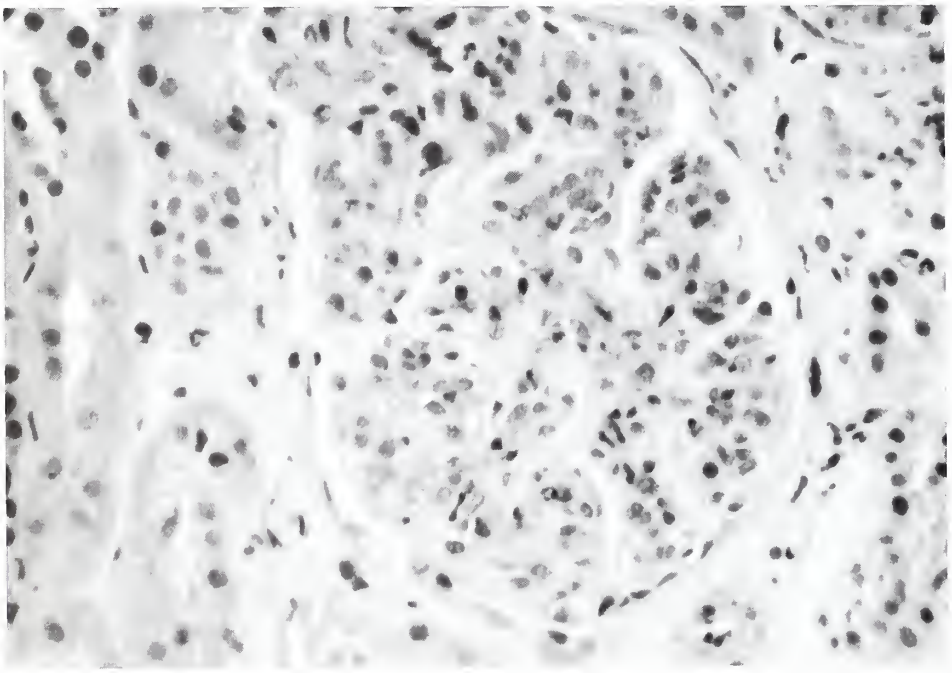

Figure 2. The glomerulus shows both endothelial cell proliferation and capillary lumen obstruction. The mesangium is also proliferative. Several PMN's are scattered throughout the glomerulus at 2, 3 and 9 o'clock.

Prognosis

The overall prognosis is quite good for the disease with an acute mortality of 0.5 percent. Deaths are most frequently due to pulmonary edema and accompanying pneumonia. On rare occasion, young children will develop hypertensive encephalopathy. Chronic problems that develop are more hotly debated.

There is no relationship in the severity of a patient's clinical presentation (BP, edema, oliguria) to ultimate outcome. Overall, children do better than adults. In Venezuela (11) where there have been follow-up studies on epidemic GN in children, less than 1 percent of individuals progressed to chronic renal failure. Most symptoms abated by one to two months with normalization of the C3 level in three to four weeks. Adults affected with the disease tended to do worse compared to children. Often on presentation, adults had crescentic patterns and were more likely to have massive subepithelial humps which were associated with longer periods of proteinuria.

Approximately 75 percent of adult individuals lost all signs of hematuria and proteinuria by five years. Fifty percent were thought to have hypertension later as a result of APGSN or had biopsy changes of glomerular sclerosis seven years after the insult (20, 21, 22, 23). This number may be relatively high due to the low number of affected adults who had complete follow-up. In addition, biopsy changes may represent scar and not true progression of disease (24).

The historical significance of acute post streptococcal GN is well established. Physicians will still encounter sporadic cases, probably one to two in their lifetime. Fortunately, the disease is self-limited and only supportive measures are usually needed. Yet, each person treating these individuals must be aware of potential complications and act in a timely matter.

Acknowledgements

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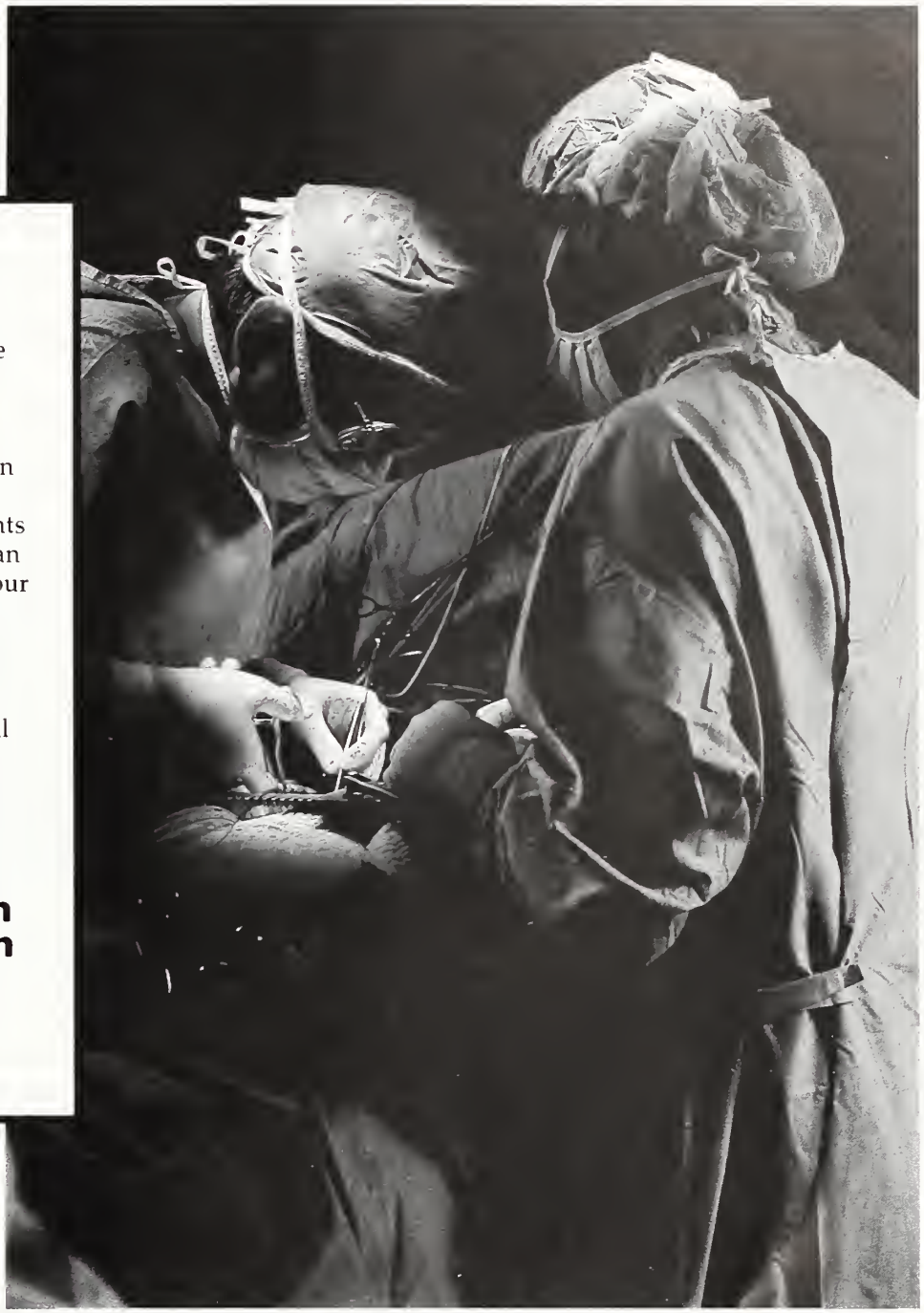

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President's Page

Michael M. Stump, M.D.

In Defense of Freedom

Discouraged after an unsuccessful day of hunting, a wolf came upon a well-fed Mastiff. He could see the dog was having an easier time of it than he was and he asked what the dog had to do stay so well fed.

"Very little," said the dog. "Just drive away the unwanted, guard the house, show fondness to the master, be submissive to the rest of the family and you will be fed and warmly housed."

The wolf thought this over carefully. He risked his life almost daily, had to stay out in the worst of weather, and was never assured of his own meals. He thought maybe he should try another way of living.

As they were going along together, the wolf saw a place around the dog's neck where the hair had worn thin. He asked what this was and the dog said it was nothing, "Just where my collar and chain rub."

The wolf stopped short. "Chain?" he asked. "You mean you are not free to go where you choose?"

"No," said the dog, "But what does that mean?"

"Much," muttered the wolf as he walked away. "Much."

— Aesop Fable

Patrick Henry was even more emphatic regarding liberty, stating, "Is life so dear, or peace so sweet as to be purchased at the price of chains and slavery? — Forbid it, almighty God! — I know not what course others may take, but, as for me, give me liberty or give me death."

Am I overstating the case for freedom? I do not think so regarding the medical profession.

Physicians that think our present liberties are secure and enduring because they are written into law, dangerously confuse legal form with the living substance of freedom. Freedom's substance is bone and marrow, muscle and sinew, joined together by intestinal fortitude in the willingness to pay the price. Anything less is the death of medicine.

The right to practice our profession in freedom did not descend on us in gentle breeze. It required our forefathers know the field, be dedicated to patients, and be recognized as knowing best the intricacies of health and disease. Even then it demanded very hard work, energy, effort, sacrifice, and even tears. Notably, this freedom came in an era of responsible individualism and particular accountability known as democracy. We neglect this freedom at our peril and to the dishonor of our medical forebearers.

The unfortunate current tendency for some in government or the legislature to manipulate laws to promote untested or theoretical concepts disguised as social or economic welfare is closely akin to the tyranny of kings. The primary motivating force of this group is often a desire for power or control. For them, any claim of seeking the people's good is an after-thought or cloak covering other motives. A second group may be sincere or sincerely deceived. They honestly believe they are doing the right thing. A final group may be simply the "Go Alongs." Membership in this group is self-explanatory.

To all I would say that there can be no true justice or legitimate law that shatters the integrity of medicine on an altar of assumed expediency. To all I would say do not go too far nor go too fast. Stop and think. Remember that "solutions" are just the beginning of other problems. Understand what you are doing and what is happening. Do not directly or indirectly further destroy health care in West Virginia.

We physicians love our profession, our famililes, our patients and West Virginia. We wanted to practice here or we would not be here. We want the best health care possible for West Virginians and we have done our part. We stand ready to do more. We will not further sacrifice or negotiate our freedom and integrity as physicians nor our responsibility as patient advocates.

The hour is late and the time is short. Come let us reason together.

Michael M. Stump. M.D.

To Good Health

There seems to be no doubt about it. We just do not want to pay the price for the level of good health and longevity available to us today.

Maybe it even makes some kind of sense. The expression "Good health is everything" is heard only from the aged or those anticipating age. It is never heard from a young person.

Youth expects good health. It is a given. They've never experienced bad health. Life *is* good health. Living is everything. Fun, joy, pleasure and satisfaction are the measures of worth. Good health? What other kind is there?

It is only after an accumulation of years, the ebbing of youthful flames of passion and an accumulation of bruises from lengthening experience in the world that thoughts turn to the quiet rewards of an absence of pain.

It is the young who complain about the expense of medical care. Why should they not? There are so many other more pleasurable things to do with money — romance, vacation, travel, clothes, cars--.

Several years ago, a study developed data demonstrating that 90 percent of the lifetime expenditures for medical care occur in the last few months of any individual's life. Why shouldn't good health be precious to the geriatric set?

In a related vein, Green Peace, Save the Whales, Save the Grizzly Bears, Nuke the Nukes, Acid Rain and other similar movements seem more like trendy yuppy games giving some "I'm a kinder, nicer, more thoughtful and considerate person that you" status to many of the ovine participants, most of whom are capable of no more thoughtful contribution to the cause than shouting slogans composed by others. They all allege some long-term philanthropic concern for the good health of coming generations. They are also quite often the very ones who campaign for free abortion and euthanasia and against the high cost and inhumanity of modern medical technology.

There's no doubt about it. It is painfully expensive to maintain good health in those with failing health. It's easier, more tempting and more attractive to spend that money on more heroic projects like saving the world from itself rather than on some hapless nobody who probably invited his own ill health by smoking, drinking other than white wine, eating high cholesterol foods and avoiding proper exercise, like jogging.

Perhaps they are right — good health is only for the young. It's too expensive for anyone else.

Stephen D. Ward. M.D.

Our Readers Speak

Preiser Only Interested in Advertising

I have read with some interest the special article "The Plaintiff's Lawyer: A Physician's Best Friend?" by Monty L. Preiser, Esq. that appeared in the December issue of *West Virginia Medical Journal.*

It is curious and somewhat puzzling that in the entire article there is no mention of tort reform or any suggestions for changes in the law. It appears that Mr. Preiser is only interested to build up more cases and work load for his law firm and his plaintiff's lawyers' colleagues. Of course to that extent, the *Journal* has provided him with a two-page free advertisement.

Sincerely,

Ali A. Garmestani, M.D.
Highlawn Medical Building
2828 First Avenue, Suite 203
Huntington, WV 25702-1292

Wolf Guarding the Sheep

I read with amusement the article written by Monty L. Preiser in your December issue. Imagine hiring the wolf to guard the sheep!

After completing his article, I concluded that Mr. Preiser was attempting to make two points:

1. that insurance companies do not have the benefit of their insureds at heart; and

2. that insurance companies protect their interests by hiring defense lawyers who are uncreative, simplistic, penny-pinching morons and who, through no fault of their own, are compelled to sell out their clients in order to further their own meaningless careers.

The point Mr. Preiser fails to address is why, if plaintiff's lawyers are physicians' best friends, do they continue to file these suits in which, as Mr. Preiser describes, "the doctor did nothing wrong and the case could well be defended?"

The plaintiff's lawyer is different from the defense lawyer in that the plaintiff's lawyer has the luxury of choosing the case. The plaintiff's lawyer has the opportunity to investigate the treatment rendered, judge the patient's claims, and determine the merit of the complaint before filing suit. The plaintiff's lawyer has the opportunity to prevent an injustice by refusing to file a meritless case. Yet day after day, I see some of those same "20 or so plaintiff's firms in this state qualified to handle major medical negligence matters," which were mentioned by Mr. Preiser in his article, filing frivilous medical malpractice suits.

I have had the benefit, as a defense lawyer, of working with insurance companies such as St. Paul, ICA, and PIE, who have the interests of their insureds at heart. Despite what Mr. Preiser believes, these companies do not put the economics of a case over the principle. I can say, from experience, that insurance companies and defense lawyers can be extremely creative and dedicated to their doctors.

Mr. Preiser's article should be viewed for its true message. At best, it is a somewhat transparent and unsophisticated marketing ploy. At worst, it is a calculated attempt to create mistrust and turmoil between physicians and their lawyers; to divide and conquer. I hope your readers see it for what it is worth.

Cheryl A. Eifert, Esq.
Jenkins, Fenstermaker, Krieger, Kayes & Farrell
1100 Coal Exchange Building
Fourth Avenue and Eleventh Street
P. O. Box 2688
Huntington, WV 25726-2688

Level the Playing Field

I read your editorial about Senator Rockefeller. Since you are such a good friend of his, perhaps you could explain to him why some of us simple hill folk are upset by the fact that Ohio physicians receive 30 percent more compensation for Medicare services than West Virginia physicians.

We are also perturbed by the fact that Pennsylvania physicians get paid 24 percent more than West Virginia physicians. I am quite certain that the vast majority of physicians in the state of West Virginia do not realize this, and would be just as upset by this fact as I am.

You might also try to find out why we pay a much higher malpractice insurance fee than the physicians in Ohio and Pennsylvania. I do not believe that our rent is any less than in the surrounding states.

Until the good Senator Rockefeller levels the playing field, I am afraid there will be little or no enthusiasm for the forward progress of his career.

James H. Wiley, M.D.
1197 Pineview Drive
Morgantown, WV 26505

Editor's Note: *A copy of Dr. Wiley's letter has been forwarded to Senator Rockefeller. We will publish any reply from him.*

Where there's smoke...there may be bronchitis

"Recent research has delineated early, more subtle changes in lung and immune functions. These alterations directly predispose smokers to respiratory tract infection."

Am Fam Phys 1987;36:133-140

Ceclor® Pulvules® 250 mg
cefaclor

Established therapy for today's patients

For respiratory tract infections due to susceptible strains of indicated organisms

Brief Summary.
Consult the package literature for prescribing information.
Indication: Lower respiratory infections, including pneumonia, caused by *Streptococcus pneumoniae, Haemophilus influenzae,* and *Streptococcus pyogenes* (group A β-hemolytic streptococci).
Contraindication: Known allergy to cephalosporins.
Warnings: CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:
• Discontinue Ceclor in the event of allergic reactions to it.
• Prolonged use may result in overgrowth of nonsusceptible organisms.
• Positive direct Coombs' tests have been reported during treatment with cephalosporins.
• Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
• Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
• Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:
• Hypersensitivity reactions have been reported in about 1.5% of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of **serum-sickness-like** reactions have been reported with the use of Ceclor. These are characterized by findings of erythema multiforme, rashes, and other skin manifestations accompanied by arthritis/arthralgia, with or without fever, and differ from classic serum sickness in that there is infrequently associated lymphadenopathy and proteinuria, no circulating immune complexes, and no evidence to date of sequelae of the reaction. While further investigation is ongoing, **serum-sickness-like** reactions appear to be due to hypersensitivity and more often occur during or following a second (or subsequent) course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults with an overall occurrence ranging from 1 in 200 (0.5%) in one focused trial to 2 in 8,346 (0.024%) in overall clinical trials (with an incidence in children in clinical trials of 0.055%) to 1 in 38,000 (0.003%) in spontaneous event reports. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy; occasionally these reactions have resulted in hospitalization, usually of short duration (median hospitalization = two to three days, based on postmarketing surveillance studies). In those requiring hospitalization, the symptoms have ranged from mild to severe at the time of admission with more of the severe reactions occurring in children. Antihistamines and glucocorticoids appear to enhance resolution of the signs and symptoms. No serious sequelae have been reported.
• Stevens-Johnson syndrome, toxic epidermal necrolysis, and anaphylaxis have been reported rarely. Anaphylaxis may be more common in patients with a history of penicillin allergy.
• Gastrointestinal (mostly diarrhea): 2.5%
• Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
• As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
• Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
• Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1% and, rarely, thrombocytopenia and reversible interstitial nephritis.

Abnormalities in laboratory results of uncertain etiology.
• Slight elevations in hepatic enzymes.
• Transient lymphocytosis, leukopenia, and, rarely, hemolytic anemia and reversible neutropenia.
• Rare reports of increased prothrombin time with or without clinical bleeding in patients receiving Ceclor and Coumadin concomitantly.
• Abnormal urinalysis; elevations in BUN or serum creatinine.
• Positive direct Coombs' test.
• False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinitest® tablets but not with Tes-Tape® (glucose enzymatic test strip, Lilly).

PA 8791 AMP (021490LRI)

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.

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AMA President to Address WVSMA Annual Meeting

Dr. Ring

John J. Ring, M.D., who is currently president-elect of the AMA, will present his remarks on Wednesday, August 14 at the First Session of the House of Delegates during the 124th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs.

Dr. Ring, a family physician from Mundelein, Ill., was elected president - elect of the AMA in June 1990. He was initially elected to the board of trustees in June 1983 and served as its chairman from June 1988 to June 1990.

Born February 2, 1928, in Washington, D.C., Dr. Ring received his B.S. and M.D. degree from Georgetown University. From 1953 to 1957, Dr. Ring served in the Medical Corps of the U.S. Navy as a Lieutenant and interned at the U.S. Naval Hospital in Philadelphia.

From 1972 until his election to the board, he served as an alternate delegate and delegate to the AMA House of Delegates, representing the Illinois State Medical Society. He was also chairman of the AMA Council on Medical Service, chairman of Work Group 6 of the Health Policy Agenda for the American People, and a member of its Steering Committee.

Dr. Ring was elected a trustee of the Illinois State Medical Society in 1977, and was chairman of its Committees on Redistricting and Health Planning. He is a past president of the Lake County Medical Society.

A founding board member, Dr. Ring served from 1975 to 1986 on the Crescent Counties Foundation for Medical Care (Illinois counties of Kane, Lake, DuPage and McHenry). In 1980 he helped create the Lake County Business Medicine Task Force on Health. In addition, from June 1984 to December 1988, Dr. Ring was an AMA Commissioner to the Joint Commission on Accreditation of Healthcare Organizations and served as chairman of the Standards and Survey Procedures Committee.

Dr. Ring represents the AMA at the World Medical Association as a member of its council and as chairman of its committee on medical ethics. He is a Diplomate of the American Board of Family Practice and is on the attending staff of Condell Hospital in Libertyville, Ill., where he serves on the Executive Committee of the medical staff.

Dr. Ring and his wife, Anne, are the parents of four children.

Dr. Lewis One of Three Finalists for ABFP Board

Dr. Lewis

The American Academy of Family Practice Physicians Congress of Delgates elected Michael J. Lewis, M.D., chairman and professor of family medicine at West Virginia University, as one of the three candidates to be finalists for the Academy position on their board of directors.

The candidates are selected according to the following criteria adopted by the 1971 Congress of Delegates:

- demonstrating leadership and understanding of the philosophy of family practice;
- having a substantial amount of clinical experience in family practice;
- demonstrating willingness and physical ability to meet commitments as the Academy's representative;
- being an AAFP member in good standing with a minimum of one re-election to membership; and
- being a Diplomate of the American Board of Family Practice.

Dr. Lewis and the other two finalists will be presented to the ABFP in April as the Academy's official nominees to fill the vacancy created by the expired term of Harmon E. Holverson, M.D., of Emmett, Ind.

Stevens Named WVSMA Associate Executive Director

Thom Stevens

Thom Stevens, a former official in the Rockefeller administration, has been named WVSMA Associate Executive Director. Stevens, a Huntington native, started in the new position on January 1.

Stevens has almost 12 years of state government experience including service as commissioner of the Department of Motor Vehicles and as an advisor to Governor Jay Rockefeller. He also served as a staff director for the Office of Legislative Services of the West Virginia Legislature and as an assistant to former Senate President William T. Brotherton Jr.

For the past five years, Stevens was president and chief executive officer of Government Relations Specialists. His firm specialized in association management services and health care consulting. Stevens also served as executive director of the West Virginia Academy of Ophthalmology.

Stevens did his undergraduate and graduate studies at Marshall University where his two daughters, Melissa and Jennifer are both now students. He was recently remarried to Pam Kabess, a marketing executive with WORLDSPAN Corporation.

"We are pleased to have Thom on the team because of his extensive experience in government, health care and association management," WVSMA President Dr. Michael Stump said. "He will direct our legislative and governmental programs and work with Executive Director George Rider on association management activities and development of non-dues revenue," Dr. Stump added.

CAMC Elects New Staff Officers, Appoints Pediatric Critical Care Director

Dr. Ayoubi

Dr. Ghiz

Dr. Lewis

Dr. Irazuzta

The medical staff at Charleston Area Medical Center has elected Mark B. Ayoubi, president; Robert L. Ghiz, chief of staff-elect; and Mary Lou Lewis, M.D., secretary-treasurer.

Dr. Ayoubi is a graduate of Damascus University School of Medicine who completed residency programs at West Virginia University Medical Center and CAMC. He is a clinical associate professor of pediatrics at WVU and MU and is board certified by the American Board of Pediatrics. Dr. Ayoubi is the founder of Mountaineer Spina Bifida Camp.

Dr. Robert L. Ghiz is a graduate of WVU and Northwestern University Medical School. He completed his residency at the Northwestern University-Cook County Hospital Orthopedic Training Program and is board certified by the American Academy of Orthopedic Surgeons.

Dr. Mary Lou Lewis is a graduate of Duke University and Emory University School of Medicine. She completed a research fellowship at Cornell University Medical School and residency programs at University of California Medical Center. Dr. Lewis is certified by the American Board of Internal Medicine and the American Board of Nephrology.

In addition, Dr. Jose E. Irazuzta has been named director of pediatric critical care.

Dr. Irazuzta is a graduate of the University of Cordoba, Argentina, School of Medicine. He completed a pediatric residency at the University of Louisville and a fellowship in pediatric critical care at The Children's Hospital, Boston and Harvard Medical School.

Dr. Morgan Speaks at ALROS Meeting

William C Morgan, Jr., M.D., treasurer of the West Virginia State Medical Association, was the guest of honor at the annual meeting of the Southern Section of the American Laryngological, Rhinological and Otological Society, in Williamsburg, Va. on January 11 and 12.

In his remarks to the Society, Dr. Morgan made some significant comments about the state of medicine today. An excerpt of his speech is as follows:

"Medicine now is in a disasterous situation. We are in need of a reasonable system, but one free of politics and interference by government as well as big business. Prudent physicians must have a significant voice in the management as well as practice of that system. We must find some way to rid medicine of the exploiters, or to control them. There is no place for the greedy and the entrepreneurs for great profit in medicine. In my experience, the legal system has not allowed physicians to address these problems."

Dr. Morgan is a former vice president and chairman of the Southern Section of the American Laryngological, Rhinological and Otological Society.

AMA Encourages PRA Involvement

During the month of April, all physicians in the state of West Virginia who do not have a current and valid Physician's Recognition Award (PRA) certificate will receive an application by mail. The application is provided as a service to both members and non-members of the AMA who might like to apply for the award.

The PRA was established by the AMA in 1968, as a means of encouraging continuing medical education and as a way of recognizing physicians who participate in continuing medical education. Over the years there has been considerable debate as to how those objectives can best be achieved, and there have been changes made from time to time in award requirements.

This year, the Continuing Medical Education Advisory Committee is recommending changes that are targeted at giving greater recognition of self-directed educational activities. One proposal, for instance, is that journal reading be a mandatory part of every PRA application.

The Committee recognizes that many physician-initiated continuing medical education activities cannot be documented. For that reason, AMA PRA Category 1 activities will continue to be mandatory also.

It has been apparent to the Advisory Committee for some time that there has been a wide spread belief that Category 1 education is first class and that Category 2 is second class. The Advisory Committee is convinced, however, that many physician-initiated Category 2 activities are of first-rate quality and that physicians should be encouraged to participate in them. The PRA program has always permitted Category 2 activities to be reported, but many applications in the past have reported only Category 1. It is hoped that in the future, greater attention and greater respect will be accorded to Category 2 educational activities.

An effort is being made also to expand reciprocity activities. The PRA program has always accepted transcripts of continuing medical education activity for review in lieu of a completed PRA application form. The program has already developed fairly extensive arrangements for reciprocity, allowing certificates from certain other organizations to be accepted in satisfaction of the PRA requirements. The program is beginning an experimental project under which transcripts from hospital continuing medical education offices are accepted as proof of an acceptable program of continuing medical education. It is hoped that this activity will make applying for the award easier for physicians and will encourage wider participation.

PRA application forms and PRA information booklets are available on request from the following address: PRA Program, American Medical Association, 515 North State Street, Chicago, Illinois 60610.

5th Annual Critical Care Update Planned for April

The Fifth Annual Review and Update Course in Critical Care Medicine has been announced by Course Directors Dr. Josepth Parillo, of Rush Presbyterian-St. Luke's Medical Center in Chicago, and Dr. Henry Masur of the Clinical Center, N.I.H.

This conference will take place at the Crowne Plaza Hotel in Rockville, Md., April 17-21 and is co-sponsored by the Society of Critical Care Medicine and Rush Presbyterian-St. Luke's Medical Center, and presented in cooperation with the Critical Care Medicine Department, The Clinical Center of the N.I.H.

The five-day course is designed to provide a comprehensive, interdisciplinary review and update on the diagnosis, monitoring, and management of the critically-ill patient. Nationally recognized leaders from the areas of cardiology, pulmonary, anesthesiology, infectious disease, and endocrinolgy will comprise the 26-member faculty for the course.

The conference is accredited by the N.I.H. for a total of 37.5 credit hours of Category 1 of the Physician's Recognition Award, by The American College of Emergency Physicians for 37.5 credits and by The American Council on Pharmaceutical Education for 4 CEU credits.

For further details contact: Svetlana Lisanti, Conference Administrator, Center for Bio-Medical Communications, Inc., 80 West Madison Avenue, Dumont, NJ 07628, (201) 385-8080.

Olgebay Park Site of WVAAP Meeting

"Issues for the Practitioner" is the title of the spring meeting of the West Virginia Chapter of the American Academy of Pediatrics which will be held April 19 and 20 at Wilson Lodge at Oglebay Park in Wheeling.

This meeting, intended for all those involved in the health care of children, will focus on current applications in infectious diseases, allergy, immunology, nutrition, adolescent medicine, and ophthalmology. The American Academy of Family Physicians has reviewed the program for 10.0 prescribed hours of CME credit.

Drs. Robert A. Lewine, Dennis L. Burech, Hsinn-Hong Wang and Judith T. Romano of Wheeling are hosting the meeting.

For information or to register, contact Donna Swickland at 243-1250.

Plans Underway for 2nd Klingberg Conference

The 2nd Annual Surgeon General's Follow-up Conference for Children with Special Needs sponsored by the W. G. Klingberg Center for Child Development at WVU will be held November 15-16 at Canaan Valley State Park.

For more information, contact the William G. Klingberg Center for Child Development at 293-7331.

Dr. Chick Retires from Marshall, Dr. Bailey Assumes CME Position

Ernest W. Chick, M.D., whose career in medicine has spanned 35 years, recently retired from the Marshall University School of Medicine and was honored by the Department of Family and Community Health.

Dr. Chick joined the Marshall School of Medicine in 1982 as a professor in the Departments of Family and Community Health and Pathology. He has also served as microbiology advisor to the Huntington VA Medical Center. In 1985, he became director of the medical school's Office of Continuing Medical Education.

Chick has specialized in the study of fungal diseases, particularly those attacking the respiratory tract and affecting rural health. He has published widely and participated in numerous state and national professional organizations.

"Dr. Chick is a distinguished researcher and has had a tremendous influence on any number of students, of whom I was one, in the field of community health," Dr. John B. Walden, associate dean for outreach and development said. He is recognized nationally as an authority on tuberculin skin testing, and is one of the people pharmaceutical companies consult when considering any changes in the test."

Dr. Chick graduated from Duke University School of Medicine in 1953 and held positions with the Duke School of Medicine, Durham Veterans Administration Hospital, West Virginia University School of Medicine, University of Kentucky School of Medicine, Lexington Veterans Administration Hospital, and the Bureau for Health Services in the Kentucky Department for Human Resources. He is listed in American Men of Science, Who's Who in the East, Who's Who in the South, and Who's Who in Kentucky.

David N. Bailey, who has served as Dr. Chick's assistant for the past three years, has been named as the new director of continuing education at Marshall.

Bailey is currently enrolled in the MBA program at MU and is a captain in the United States Army Reserve Engineer Corps. He serves on the Admission and Annual Research Day Conference Committee at Marshall and on the medical education committees for Cabell Huntington Hospital and St. Mary's Hospital.

PMA Adopts New AMA Ethical Guidelines

The Board of Directors of the Pharmaceutical Manufacturers Association has adopted the AMA's new ethical guidelines for physicians. The six AMA guidelines are being made part of the PMA Code of Pharmaceutical Marketing Practices.

"Physicians must be adequately informed about the availability of an important new therapy and current about its uses or patients will be poorly served," PMA President Gerald J. Mossinghoff said. "Marketing and promotion are essential to achieving these objectives. It is appropriate for new promotional practices to continue within the framework of the AMA Guidelines on Gifts to Physicians from Industry.".

The PMA Board also recently adopted the American College of Physicians' four position statements on relationships between physicians and the pharmaceutical industry.

The Pharmaceutical Manufacturers Association is a non-profit, scientific and professional organization of more than 100 member companies that discover, develop and produce most of the prescription drugs used in the United States.

Siemens Sponsors Breast Cancer Diagnosis Seminar

Siemens Medical Systems, Inc. is sponsoring a three-day workshop conference on interventional procedures for breast cancer diagnosis, June 17-19, at the Westin Resort, Hilton Head, S.C.

This workshop is AMA accredited and is open to radiologists, pathologists, surgeons, cytologists, and technologists. It is being presented by the Mallinckrodt Institute of Radiology at Washington University and features experts from around the world discussing stereotactic technique for aspiration biopsy (FNAB); stereotactic localization for surgical biopsy; ultrasound guided procedures; cyst punctures, and ductography.

For additional information contact: Siemens Medical Systems, Inc., Mammography Group, Conference Planning, 125 N. Executive Drive, Suite 302, Brookfield, Wis., 53005, 414-784-1455.

Lung Association Offering NIOSH Spirometry Course

The American Lung Association of West Virginia is offering a Spirometry Training Course approved by the National Institute for Occupational Safety and Health (NIOSH) on Wednesday, April 10 and Thursday, April 11 at the John XXIII Pastoral Center in Charleston. This course is designed to give respiratory therapists, nurses, physicians and allied health professionals instruction in this area of diagnostic medicine.

Dr. Daniel Banks, associate professor and chief of the section of pulmonary and critical care medicine at West Virginia University, will be the course director. The registration fee for the course is $210 which includes all materials, lunches, and break refreshments.

For information, please contact Shawn Harris Chillag at 342-6600.

NCPIE Conference Set for April

"Managing Diversity in Medicine Communication" is the theme for the 8th National Conference on Prescription Medicine Information and Education to be held Sunday, April 21 - Tuesday, April 23 at the Omni Shoreham Hotel in Washington, D.C.

Plenary sessions will highlight international approaches to medication information and education; risk reduction through communication; new research, and the use of social marketing techniques to improve medicine use by adults. Skill-building workshops, poster sessions, exhibits, and a breakfast session are also scheduled.

For registration information, exhibitor's prospectus, and poster guidelines, write to: NCPIE Conference, 666 Eleventh Street NW, Suite 810, Washington, D.C. 20001, or call (202) 347-6711.

Financial Seminar To Be Held in Hilton Head

The Medical College of Georgia has scheduled their annual Financial Management Conference for Physicians and Dentists for August 1-3 at the Mariner's Inn, Hilton Head Island, S.C.

This will mark the 15th year for the conference, which is designed to provide up-to-date information concerning current economic trends and specific strategies for insuring continued effective operation for practice. Speakers will provide specific recommendations and ideas to improve financial management practices, develop office or other commercial real estate, and the wise investment of revenues, to include overall estate planning.

Registration information can be obtained from the Division of Continuing Education, Medical College of Georgia, Augusta, Ga. 30912. The toll free number is 800-221- 6437 (in Georgia (404) 721-3967).

Otolaryngology Annual Meeting Scheduled

The West Virginia Academy of Otolaryngology—Head and Neck Surgery Inc. will hold their annual spring meeting at The Greenbrier in White Sulphur Springs from May 24-27.

Guest speakers for the event will be Richard T. Farrior, M.D., F.A.C.S.; Michael E. Glasscock, III, M.D.; and David E. Schuller, M.D., F.A.C.S. The meeting is approved for AMA credit category I, 12 hours otolaryngology.

Registration fee is $150. Write to F.T. Sporck, M.D., P.O. Box 1628, Charleston, WV 25326-1628.

1991 USP Catalog Available Free

The United States Pharmacopeial Convention, Inc. (USP) has published their 1991 Catalog of Publications and Services. The 32-page catalog contains complete descriptions and ordering information for all USP publications, computer applications, and services available.

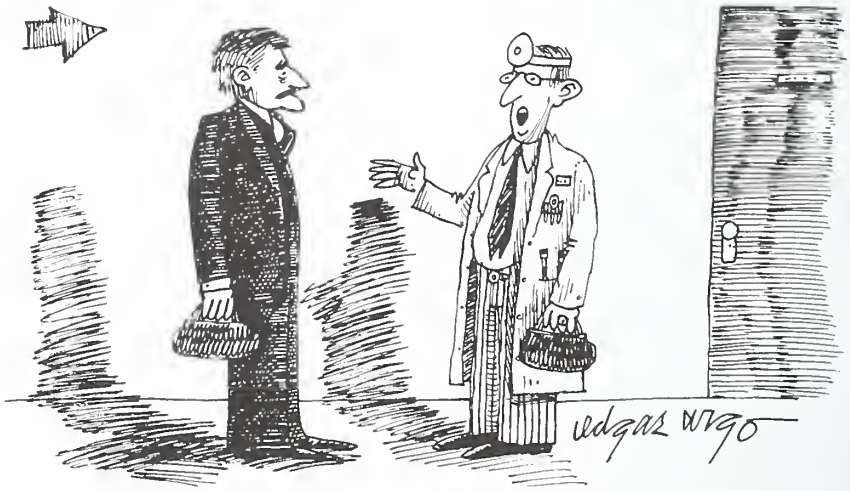
The 1991 catalog is divided into sections titled Drug Information, Patient Education, Drug Standards, Computer Applications, and Services.

This publication is available free by writing to 1991 USP Catalog, 12601 Twinbrook Parkway, Rockville, MD. 20852, or by calling 1-800-816-8148.

Study Compares Glaucoma Treatments

Results of the Glaucoma Laser Trial (GLT), sponsored by the National Eye Institute were recently presented at the Annual Meeting of the American Academy of Ophthalmology and suggest that Argon laser surgery may be a safe and effective alternative to eye drops as a first treatment for patients with newly diagnosed open-angle glaucoma. The GLT is being conducted at 11 centers in the U.S., including eight clinics.

However, because open-angle glaucoma is a chronic disease, study patients will continue to be followed up to three additional years to assess further the value of both treatments. After two years of treatment, the mean intraocular pressure of eyes in the "laser first" treatment group measured about two lower than that of eyes treated with eye drops only. The laser-first eyes generally required less medication to control pressure than the eyes treated with eye drops only. Visual acuity and visual field changes were the same for both groups of eyes.



"PEOPLE DON'T BOTHER ME WITH THEIR PROBLEMS AT PARTIES ANY MORE.... I STARTED ASKING THEM FOR URINE SAMPLES."

Continuing Education

Listed on this page are some of the upcoming continuing education programs which will be held throughout the state.

The programs this month were compiled by the following individuals: Suzanne Nowell, WVU outreach coordinator of continuing medical education; Robin Rector, coordinator of continuing medical education for Charleston Area Medical Center; and Arlene S. Feder, M.D., coordinator of Medical Grand Rounds for Ohio Valley Medical Center.

These programs are tentative and subject to change. Further information about these CME activities may be obtained by calling Nowell at 293-3937; Rector at 348-9580; and Feder at 234-1835. Other national and state meetings are listed in the Medical Meetings section of the *Journal*.

This schedule is presented as a convenience for physicians. If you would like to have the continuing education programs offered by your institution or association published in the *Journal*, please contact Nancy Hill, managing editor, at 925-0342 or 1-800-257-4747.

CAMC/WVU Health Sciences Center - Charleston

February 25 - "Neonatology Update: The Neonate and Substance Abuse," 12:30 p.m. - 1:30 p.m. (tele-conference) WVU Bldg. Room 2044

Ohio Valley Medical Center - Wheeling

February 13 - "Conceptualization of Chronic Pain: Implications for Evaluation and Treatment," Dennis C. Turk, M.D. 8:00 a.m.

February 27 - "Veins," John D. Holloway, M.D. 8:00 a.m.

CME Outreach Programs

Key to Sponsors

★ WVU Health Sciences Center, Morgantown

☐ CAMC (•)/WVU Health Sciences Center-Charleston (△)

(Check locally for additional information)

Fairmont ★ Fairmont Clinic, February 20, 1 p.m., "Review of Cellular Immunity to Include the Mechanisms of Cellular Immunity, the Mechanisms of Allergy, the Mechanisms of HIV Infection and the Mechanisms of Proposed Vaccination Against HIV," Wesley Farr, M.D.

Logan ☐ Logan General Hospital, February 15, 11:30 a.m., "Shock," Jose Irazuzta, M.D.

Man ☐ Man Appalachian Hospital, February 19, 7 p.m., "Hypertension," Julian Espiritu, M.D.

Grantsville • Calhoun General Hospital, February 28, TBA.

Montgomery ☐ Montgomery General Hospital, March 6, noon, "Update on TIA's," John Schmidt, M.D.

New Martinsville ★ Wetzel County Hospital, February 14, 11:30 a.m., "Headaches," Ludwig Gutmann, M.D.

Parkersburg ★ Camden Clark Memorial Hospital

February 13, 7:30 a.m., "Cochlear Implants — New Technology for the Profoundly Deaf," Stephen Wetmore, M.D.

February 20, 7 a.m. "Management of Obesity," Irma Ullrich, M.D.

February 27, 7 a.m., "Approach to Evaluation and Treatment of Cardiac Arrhyrhmias," Stanley Schmidt, M.D.

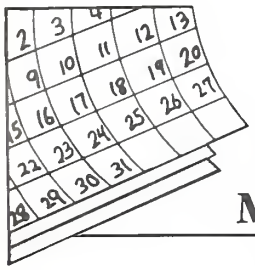
Point Pleasant ☐ Pleasant Valley Hospital, February 28, noon, "Neonatal Resusitation," Stefan Maxwell, M.D.

Ripley ☐ Jackson General Hospital, March 8, "Neonatal Resusitation," Stefan Maxwell, M.D.

Ronceverte ☐ Humana Hospital - Greenbrier Valley, February 20, 1 p.m., TBA

Spencer ☐ Roane General Hospital, February 19, 12:30 p.m., "Legal Issues for MDs, Paula Branfass.

Waynesburg, Pa. ★ Greene County Memorial Hospital, February 26, 7 p.m., "Mechanical Ventilation," Luis Teba, M.D.



Medical Meetings

February

16-18—American Association for Geriatric Psychiatry, Ft. Lauderdale, Fla.
20—How to Manage a More Profitable Practice, Southern Medical Association, Orlando, Fla.
22-23—Infectious Disease 1991: Current Problems, Ohio State University, Columbus.
28-March 2—Advances in Pulmonary and Critical Care Medicine, Southern Medical Association, Montego Bay, Jamaica.
28-March 2—What Works: Bridging the Gaps for America's Children, Children's Defense Fund, Washington, D.C.
28-March 3—The Ninth Annual International Symposium on Man and His Environment in Health and Disease, The American Environmental Health Foundation, Dallas.

March

1-2—The 34th Annual Postgraduate Symposium in Ophthalmology: Current Concepts in Ocular Inflammation, Ohio State University, Columbus.
7—How to Manage a More Profitable Practice, Southern Medical Association, Durham, NC.
7-8—High Risk Obstetrics: The Problem Pregnancy, Ohio State University, Columbus.
8-9—Second Annual Ophthalmology Alumni Weekend WVU Department of Ophthalmology, Morgantown.
15-16—Lipids, Ohio State University, Columbus.
15-17—Office Management of Infectious Diseases, Southern Medical Association, Destin, FL.
21-23—Introductory Perimetry Course, Ohio State University, Columbus.
21-22—Standards of Care and Recertification, American Boards of Medical Specialties, Chicago.

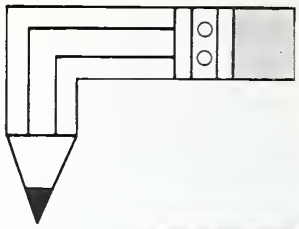
April

5-6—Geriatric Clinical Update: Treatable Cases of Dependency, Ohio State University, Columbus.
10-13—A Comprehensive Review of Clinical Obstetrics and Gynecology, Georgetown University Medical Center, Washington, D.C.
17-21—Critical Care Medicine 91, Society of Critical Care Medicine and Rush - Presbyterian - St. Luke's Medical Centers, Rockville, Maryland.

For More Information . . .

Contact The Journal for additional information about most of the above meetings. Call (304) 925-0342.

Poetry Corner



Tragedy Averted

I am so relieved —
Earlier today when watering the lawn
I began to believe
That the parents of those twittering wrenlets
In the wren house underneath the eaves
Were gone forever.

I saw not hide nor hair
Of parental supervision, and thought
Perhaps the cats that prowl our place
Had scared away, or even caught
(God forbid) the tippy-tailed progenitors
Of our current crop of wrens.

But later on as sun went down,
The tragedy of the day was stayed,
When in the hush of summer eve
Jenny and her mate relayed
In sweeping flights in and out of the tiny house,
Bearing gifts.

R. L. Smith, M.D.

Nebraska February

The wind
rustles empty pockets
outside Omaha busstops
homesick Sioux shiver
huddle
stare into the night
and wonder where they will sleep.

The wind
a fist in his face,
fifty miles from anywhere
a sandhills Rancher
fumbles truck keys
with stiffening fingers
curses his icy breath
and prays his cattle won't freeze before dawn.

Above Box Butte county
the wind-chill pauses
at 80 below
the moon and stars
groan and crack
and the spirit of Tashunka Whitko[1]
restless for over a century
drifts slowly toward the Running Water.[2]

Donald Frey, M.D.

1. Crazy Horse
2. Niobrara River

Please address your submissions for Poetry Corner to: Stephen D. Ward, M.D., Editor, West Virginia Medical Journal, Box 4106, Charleston, WV 25364.

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Compiled from material furnished by the West Virginia University Health Sciences Center News Service, Morgantown.

Medical Planning for Terrorist Attacks Falls Short

Americans who dial 9-1-1 during a terrorist attack may not get the help they need because of inadequate planning, according to Dr. John E. Prescott, medical director for emergency medical services at West Virginia University.

"People think that all they have to do is pick up the phone and the person on the other end will know how to handle a terrorist incident," Dr. Prescott said. "The bottom line is that just isn't true and we could do a whole lot better with some better procedures."

Dr. Prescott explained that existing emergency plans usually are drawn up for floods and other natural disasters, not the sudden violence, severe wounds and psychological trauma seen in a terrorist attack.

"The problem is there is a significant difference in dealing with victims of terrorism and people hurt in a tornado," Dr. Prescott said. "You see different types of injuries in terrorism, people are out to hurt you. You want to know why. It's senseless. You panic because it seems you've lost control."

Although the Federal Bureau of Investigation has said it has no evidence of increased terrorist activity in this country, the agency boosted surveillance efforts after Iraqi leader Saddam Hussein said he would use any means possible to widen the Persian Gulf war.

The sudden death of one Iraqi and the wounding of another as they apparently tried to plant a bomb at U.S. offices in the Phillipines indicates Saddam's threat is not an empty one, Dr. Prescott commented.

"Most municipalities, even those with well-developed anti-terrorist units, have failed to consider the medical implications of a terrorist act," Dr. Prescott commented. "The emphasis in planning has been on the law enforcement and legal side. A community could have the best SWAT team in the world and still end up with a lot more casualties because it failed to include emergency medical services and physicians in the plan," he elaborated.

Dr. Prescott, an assistant professor of emergency medicine, has written a chapter on terrorism and emergency medicine for a medical textbook scheduled to be published this fall. He also has given lectures to professional medical organizations on the subject.

Conference to Discuss Issues in Cancer Care

"Living with Cancer Oncology: Update 1991" will be the topic of the West Virginia University School of Medicine's Continuing Medical Education Conference March 14-16 at the WVU Health Sciences Addition Auditorium.

The conference, which is designated for internists, general surgeons, family practitioners, osteopaths, hematologists, oncologists, nurses and other health care professionals, will outline important issues in the detection, diagnosis and treatment of cancer of the breast and other common cancers.

The program also will discuss major factors in prevention and early detection of breast cancer, limitations to cancer screening and detection methods, and the natural history and major treatment modalities for cancer of the breast, prostate, esophagus and lung.

For more information about the conference, call the CME office at 293-3937 or 1-800-WVA-MARS.

Lung Disease Study First in U.S.

Researchers hope a five-year, 1.5 million study to detect and treat lung disease in the workplace will help employees at Weirton Steel Corp. breath easier.

"No one else in the country has this kind of program," Dr. Daniel Banks, associate professor of medicine at West Virginia University and the study's principal investigator said. "When completed, the study will serve as a national model for steel and other industries where dust, chemicals and other airborne agents threaten the lungs of workers."

According to Dr. Banks, participants will be screened for symptoms of airway obstruction, abnormal breathing patterns, emphysema, asthma and bronchitis. Results from annual health evaluations, lung function tests and chest X-rays will be used to calculate the risks of pulmonary deterioration faced by independent workers.

The employees studied will be organized by work areas and job titles to identify possible sites and jobs associated with decline of lung function. Dr Banks hopes to identify relationships between length of employment, smoking, medical history, work sites and lung functions.

Miles Funds Pediatric Study

West Virginia University recently received a $50,604 grant from Miles, Inc., to fund a project entitled "Multi-Center, Prospective, Randomized, Third-Party Blind Comparison of Oral Ciprofloxacin Versus Continued Parenteral Ceftazidime in Neutropenic Pediatric Cancer Patients Who Have Responded to Initial Parenteral Therapy."

Dr. A. Kim Ritchey, associate professor of pediatrics, is the principal investigator for the study.

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MU School Of Medicine News

Compiled from material furnished by the Office of University Relations, Marshall University.

Szarek Awarded Two Major Grants for Pulmonary Studies

Dr. John L. Szarek of the Marshall University School of Medicine has received grants totaling over $100,000 for research on how certain adverse conditions may affect pulmonary function.

A six-month study on how chronic exposure to ozone affects airways of the lungs is of particular interest to tri-state residents, according to Dr. Szarek, an associate professor in the Department of Pharmacology. "Those of us living here are often exposed to high ozone levels, in fact, this area has a significant ozone problem," Dr. Szarek said.

The $58,000 study is sponsored by the Health Effects Institute, an independent non-profit corporation located in Cambridge, Massachusetts, which supports research on the health effects of motor vehicle emissions. The institute contributes its findings on health risks to the U.S. Environmental Protection Agency which then uses such data to set standards for ozone and other air pollutants.

Ozone results from complex photochemical reactions between automotive emissions and other pollutants and sunlight, Dr. Szarek said. Though a large body of evidence shows that ozone is an acute respiratory irritant and can produce symptoms such as cough and shortness of breath, limited data exists on the long-term health effects of ozone exposure.

Dr. Szarek's laboratory studies of chronic ozone exposure begin next summer. Since the lung samples he will be working with have to be shipped to him, Dr. Szarek was awarded $32,000 this fall to determine the best way of keeping the tissues viable in transit.

Dr. Szarek also has underway a study for the United States Air Force. The Air Force study explores how high levels of oxygen administered under pressure during certain medical procedures affect the lungs. Due to the fact these procedures called hyperbaric oxygenation, expose the patient to oxygen levels much greater than those in air, adverse effects on the airways of the lungs are of major concern, Dr. Szarek explained. Hyperbaric oxygenation is often used during treatment of combat injuries and also has civilian applications.

The $18,500 grant, which comes through the U.S. Air Force's Office of Scientific Research/Universal Energy Systems, allows Dr. Szarek to continue studies which he began last summer as a summer fellow in the Hyperbaric Medicine Division at the School of Aerospace Medicine, Brooks Air Force Base in San Antonio, Texas.

Geriatric Center Relocates to St. Mary's Hospital

Marshall University's Frank E. Hanshaw Sr. Geriatric Center recently opened the doors of its new home at St. Mary's Hospital.

The Hanshaw Center, which provides comprehensive health evaluations for senior citizens, is now located on the sixth floor of St. Mary's Nursing Education Center. Director of the Hanshaw Center Dr. Shirley Neitch said the new location will allow for consolidated services to the elderly.

"By being here at the hospital, we can offer our patients laboratory and X-ray services right on the premises," Dr. Neitch said. "In addition, the center has specially-trained geriatrics physicians, nurses, social workers and a neuropsychologist who all have an interest in the health care needs of the elderly."

Dr. Joye A. Martin, who has been closely affiliated with the Hanshaw Center since its inception, remains on the staff and will continue to alternate as director with Dr. Neitch.

The Hanshaw Center specializes in certain aspects of geriatric medicine and features a special clinic to treat the trauma associated with falls. Dr. Neitch said the staff also works to prevent polypharmacy (the taking of too many different medications) among seniors. Dementia (a state of mental deterioration often related to Alzheimer's) and cognitive disorders are also treated.

Created in 1988 with a $1 million grant from the Huntington Foundation, the Hanshaw Center was formerly located in HCA River Park Hospital.

"Through our association with HCA River Park Hospital, we were able to see the Hanshaw Center off to a solid beginning," Dr. Charles H. McKown, Jr., dean of the Marshall University School of Medicine said. "We are now looking forward to working with St. Mary's to expand our direct services to the elderly as well as to enhance our educational program in geriatrics for medical students and residents."

J. Thomas Jones, executive director/CEO of St. Mary's, said he was extremely pleased to have the Hanshaw Center on St. Mary's campus. "The Hanshaw Center offers an array of needed services for patients and will serve as the cornerstone of the hospital's program to expand services for senior citizens."

The Hanshaw Center is a division of the John Marshall Medical Services and is operated jointly by the Departments of Medicine and Family and Community Health. Appointments can be made by calling Hanshaw Center at 526-1500 or the MU School of Medicine referral system at 696-7288 or toll free 800-342-7288.

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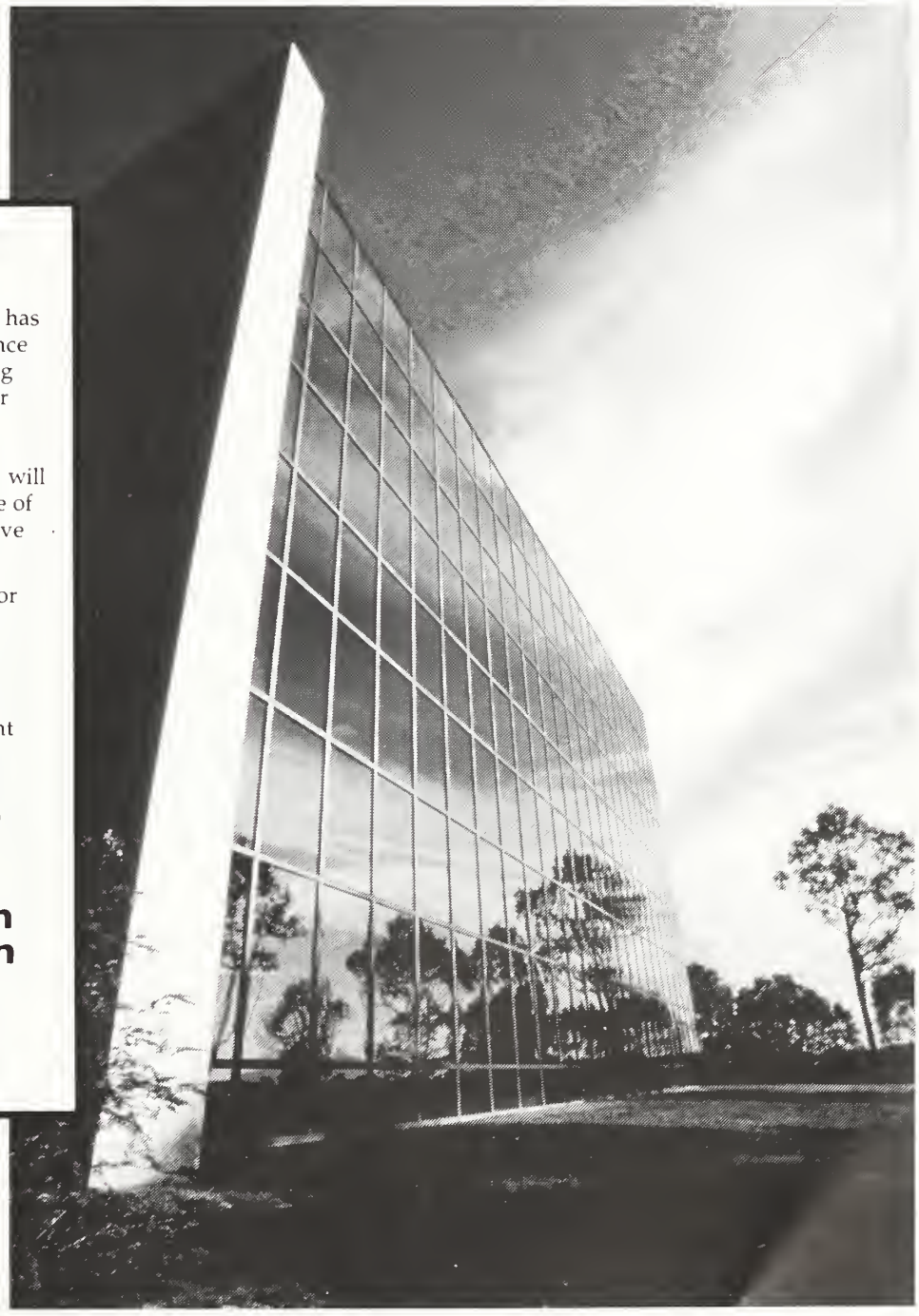

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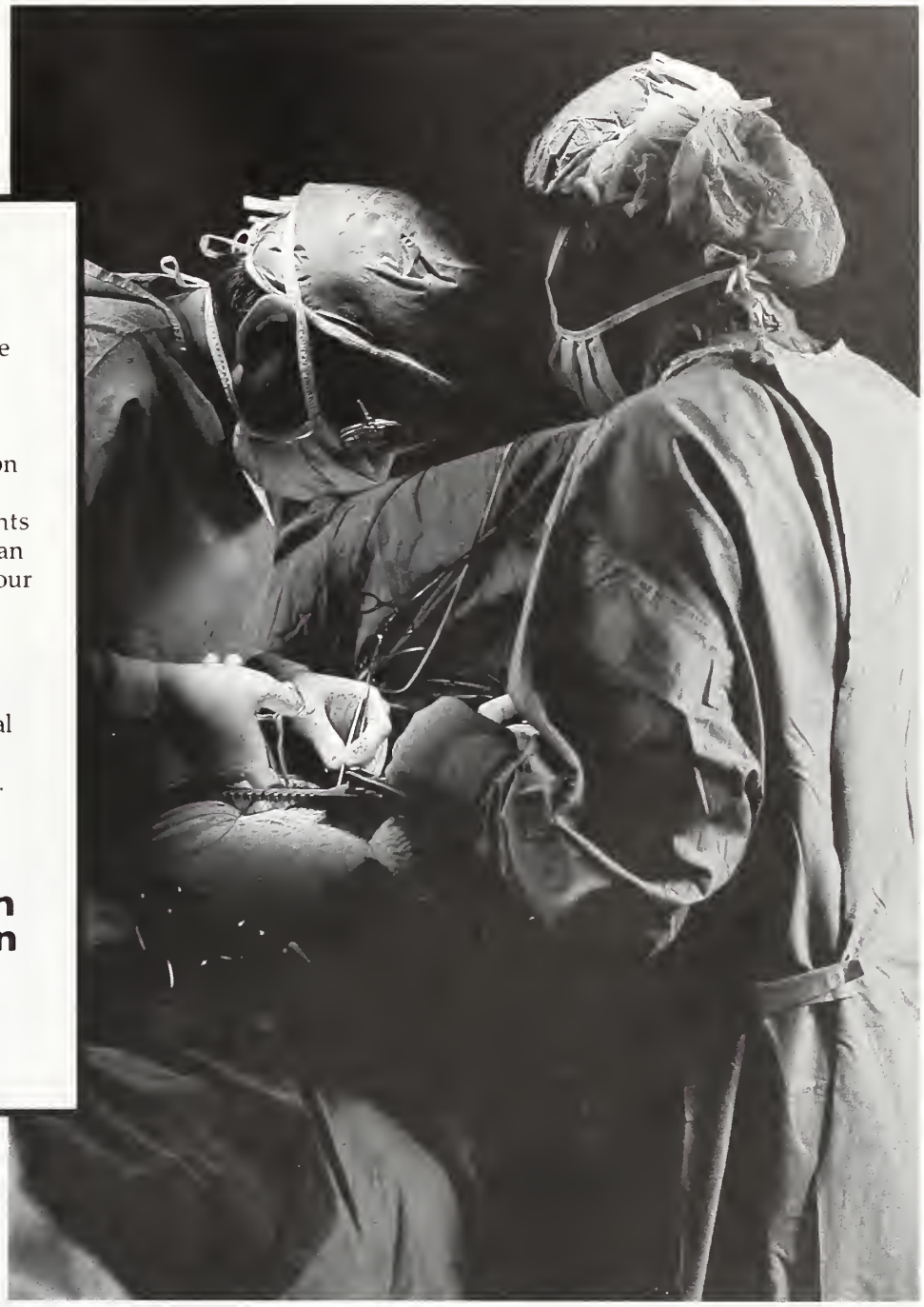

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The magnificent State Capitol in Charleston proudly displays its new gold dome. Photo courtesy *Stephen J. Shaluta Jr., West Virginia Department of Commerce.*

WVSMA's Proposed Solutions to Indigent Care

Editor's Note: *WVSMA President Michael M. Stump, M.D., charged the Indigent Care Committee of the Association with the task of defining the basic health care needs of the citizens of West Virginia. Dr. Stump requested that the Committee evaluate basic health care needs, define adequate health care and look at how that care can be provided with the dollars available. The following is the report which was completed by Dr. Bill Atkinson, as charged by the Executive Committee at their meeting on January 25.*

Adequate Health Care

Adequate health care must be considered in two specific areas, first and foremost, it is imperative that preventive health care be provided in a planned and realistic fashion. This care should begin at birth and continue till death. Preventive medicine will have the overall effect of extending life in a more comfortable and productive fashion by reducing hospitalization, decreasing the need for medications, and reducing the occurrence of communicable diseases. Many states now have realized that for every dollar spent on preventive medicine, $4 can be saved on future care. Second, quality, cost effective, acute care must be provided when chronic and acute illnesses do occur.

Preventive health care must provide child care with screening for congenital disorders, primary immunizations, and routine wellness examinations. Adults have to be provided with wellness examinations, to include such items as Pap smears, chest X-rays, skin testing, immunization boosters, lipid profiles and other evaluations as age and symptoms indicate.

In addition, there has to be continuous educational reinforcement in risk factors of cancer, heart and vascular disease, accidents, aging, and lifestyles. With 53 percent of today's accidents and illnesses being preventable, the overall cost of medical care could be reduced simply by changing lifestyles.

Table I gives an outline from The American Journal of Preventive Medicine considered minimal preventive care for all people. The cost for these services would range from $20 to $200 per year.

In addition, care must be provided for the acute and chronic illnesses that occur throughout life. In order to determine what is an adequate level of provided acute and chronic care, we use the recommendations of the American Medical Association's Report KK (Annual 90) (Table 2). The items listed in Table 2 have been extracted from that report and modified to be compatible with a strong preventive health care program.

Table 1 - The American Journal of Preventive Medicine's Lifetime Schedule of what is Considered Minimal Preventive Care for All People

Age (yrs.)	*No. visits*	*Each visit to include*
0-2	5	History and physical exam: Primary immunizations: DPT, OPV, MMR Hib. Parent education re: growth and development, childhood risk factors.
2-17	5 (every 2-3 yrs.)	History and physical exam: blood pressure starting at 3 years. Immunization: DPT and OVP boosters. Patient and parent education re: good health habits, social adjustments and risk factors of adolescence.
18-39	5 (every 5 yrs.)	History and physical exam: height and weight, BP and breasts. Lab tests: Plasma total cholesterol and glucose. Pap smear every 3 years. DT booster. Patient education re: risk factors of cancer heart disease and accidents.
40-49	3-4 (every 3 yrs.)	History and physical exam: weight, BP, breasts and rectal, hearing screening. Lab tests: Cholesterol glucose or chem battery. Pap smear every 3 years. Stool for occult blood. Tetanus booster. Patient education re: risk factors of cancer, heart disease and accidents.
50-64	5 (every 3 yrs.) Annual stool for occult blood and mammography	History and physical exam: weight, BP, breasts and rectal, hearing screening. Lab tests: Cholesterol glucose or chem battery. Pap smear every 3 years. Tetanus booster. Patient education re: risk factors of cancer, heart disease, accidents and aging.
65-74	5 (every 2 yrs.) Annual stool for occult blood and mammography	History and physical exam: weight, BP, breasts and rectal, hearing screening. Lab tests: Cholesterol glucose or chem battery. Pap smear every 3 years. Tetanus booster and influenza. Patient education re: risk factors of cancer, heart disease, accidents and aging.
75 +	Every year stool for occult blood and mammography	History and physical exam: weight, BP, breasts and rectal, hearing screening. Lab tests: Cholesterol glucose or chem battery. Pap smear every 3 years. Tetanus booster and influenza. Patient education re: risk factors of cancer, heart disease, accidents and aging.

Access

Having means to pay for health care is not always a guarantee of access to that care. The West Virginia State Medical Association's Ad Hoc Committee on Health Access made several recommendations to the Associations Council last summer, some of which will be expanded in this report.

One of the major recommendations was to develop and utilize a managed care program for Medicaid in the form of a "gatekeeper" system similar to the system that is used in Kentucky. Currently, this in the process of being implemented and will be called The West Virginia Physician Assured Access System (WVPAAS). The Department of Health and Human Services is currently waiting for a waiver from HCFA to implement the plan. While this will be successful in decreasing the abuse in the Medicaid system, there may be some difficulty in getting physicians to volunteer to act as the health care managers. Physicians seem to have two major objections to this approach; one, they feel that it will increase their liability and two, they do not want to be obligated for availability 24 hours a day, seven days a week. Even though our committee was convinced that money could be saved, they felt that the decision to participate in such an effort would still be up to individual physicians.

Another major avenue of health care access for the indigent is for the state, through its county health departments, and other organizations, i.e., WVSMA, WVHA, the medical schools, and churches, to develop clinics that would be staffed by volunteer physicians in all areas of specialty practice. This would be the most productive and least expensive way to get free health care to the indigent population of West Virginia.

In order to insure that the volunteers are protected from liability for their free service, the state should pass laws similar to the laws in South Carolina and in Utah that give immunity from liability for volunteer physicians, provided that patients are informed prior to service that the care is free. This type of protection would apply unless there was wanton and gross negligence. If, by chance, the Legislature did not want to interfere with the indigent patient's constitutional right to sue, in case of maltreatment, then the state should be willing to provide liability insurance for all volunteer providers for such clinics.

There are many healthy and experienced physician retirees in West Virginia that would be happy to donate a day or two a week in free clinics. The problem is, they can't afford to purchase the practice liability insurance to protect themselves from suits. If they were protected from liability, and if they were able to provide free care on a retired status medical license (which the Legislature could remedy), many thousands of hours of good care could be given to thousands of indigent patients annually. Therefore, we recommend that retired physicians be permitted to provide care in free clinics on a "retired status" license and have liability protection provided by the state in one of the two ways mentioned.

There needs to be some type of a confident access system for the uninsured indigent to ensure that they also have health care availability even if it is only on a short-term basis. One of the ways of doing this is to develop a "health access network" similar to the Kentucky Health Care Access Foundation (KHCAF). This organization provides an 800 telephone number from any location within the state, so indigent patients can access needed care. This was started originally by the Kentucky State Medical Association, the University of Kentucky, and the University of Louisville. It is now operated as a foundation and supported by many organizations and industries. The KHCAF has made over 30,000 "one-time" referrals in the five years of its existence.

It is recommended that the WVSMA, in a cooperative effort with other major health care providers, including hospitals and insurance companies, develop a system similar to the KHCAF for West Virginians.

The state needs to develop a broader method of funding for Medicaid in order to obtain more federal matching funds. The major effect would be to provide uniform adequate benefits to all persons below the poverty level. It is essential that this be done to enable the best care for the indigent and should be a first priority.

This plan provides health care services and provides the most health care for the dollar.

Table 2 - Recommendations of the AMA's Report KK (Annual 90) on How to Determine an Adequate Level of Provided Acute and Chronic Care

COVERED BENEFITS

1. Medically necessary services as determined by physicians (both DO and MD)
2. Office visits (limited to 20 per person per year)
3. Outpatient services
4. Inpatient room, board, and ancillary (limited to 45 days per year)
5. Skilled nursing facility (180 days per year per person)
6. Home health care (240 visits per person per year)
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8. Dental (limited to repair from injury)
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6. Obesity treatment and weight loss control programs
7. Custodial or domicilary care
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AIR FORCE

New Events Add to Success of Mid-Winter Meeting

Two pre-convention seminars, "Politics, The Media and You," and "Practical Applications for Maximum Reimbursement," were among the many highlights of the 24th Mid-Winter Clinical Conference, January 25-27 at the Holiday Inn-Charleston House.

Approximately 359 physicians, residents, students, nurses and exhibitors attended this year's meeting. In addition to the two pre-convention seminars, other activities offered for the first time included a meeting for medical student members and a luncheon for all attendees in the Exhibit Hall. A special presentation on "What West Virginia Physicians Need to Know About Advance Directives," was given prior to the First Scientific Session by Alvin H. Moss, M.D., director of the Center for Health Ethics and Law at West Virginia University.

The four scientific sessions, "Update on Thyroid Disease," "Controversies in Medicine," "Trauma Management," and "Potpourri of Topics - Updates," were well attended and drew lively dialogue from the audience. Especially pertinent were the physician and public sessions, "Rationing of Care," and "Adolescent Sexual Behavior: Problems and Solutions."

Plans are already underway for next year's Mid-Winter Conference which will be held in Huntington from January 24-26.

WEST VIRGINIA STATE
Medical Association
24th
MID-WINTER
Clinical Conference

All of the scientific sessions were well attended at Mid-Winter, especially the Saturday morning presentation on "Controversies in Medicine."

Delegate Mark Harmon presented an in-depth look at the legislative process during "Politics, The Media and You," a seminar held for physicians and auxilians on Thursday, January 24 prior to the start of the Mid-Winter Clinical Conference. This public relations workshop was conducted by Linda Arnold (seated at left), president of The Arnold Agency.

WEST VIRGINIA STATE

Medical Association

24th

MID ▲ WINTER

Clinical Conference

Delegate Peggy Miller, Dr. Lee Neilan and her daughter Joyce, a 4th-year WVU medical student, Dr. Tom Potterfield, Mary McJunkin Gray and Dr. Joe Skaggs were among the many guests who attended the WVSMA Legislative Reception.

WVSMA Executive Director George Rider, President Michael Stump and Associate Executive Director Thom Stevens discussed legislative issues with doctors attending the luncheon meeting for the WV Chapter of the American Academy of Family Physicians.

Delegate Nancy Kessel visited with Priscilla Stump, wife of WVSMA President Michael Stump, and Thom Stevens, WVSMA associate executive director, at the Legislative Reception.

Linda Turner, coordinator of the Family Life Program in Huntington, and Dr. William Cunningham listen intently to Dr. Richard Keeling's presentation during the Public Session on "Adolescent Sexual Behavior: Problems and Solutions." Mrs. Turner was one of the four speakers for this panel which Dr. Cunningham moderated.

Dr. Albert Moss narrates slides during his presentation on "What West Virginia Physicians Need to Know About Advance Directives."

Steve Brown of McDonough Caperton and Julie Ayers of CNA give insurance information to one of the physicians visiting their booth in the Exhibit Hall.

Taunja Willis Miller, secretary of the WV Department of Health and Human Services, and Sally Richardson, director of the PEIA, were two of the panelists for the Physician Session on "The Rationing of Care," which was moderated by WVSMA President Michael Stump.

Dr. Joseph Touma, president of the Cabell County Medical Society, talked about issues facing his society at the luncheon for the WVSMA component societies.

Dr. Ronald McCowan delivers his address on "Management of Malignant Ventricular Arrhythmias: Recent Experience at CAMC."

Teenage penpals Dr. Araceli Almond Ganan of Buckhannon and Dr. Shunzaburo Iwatsuki of the Falk Clinic in Pittsburgh were reunited at the Mid-Winter Meeting. They began writing to each other when he was a pre-med student in Japan and she a young teenager in the Philipines. Dr. Iwatsuki was one of the speakers for the Fourth Scientific Session and Dr. Ganan was delighted to have the opportunity to see him again after being out of touch for the past 10 years.

WEST VIRGINIA STATE

Medical Association

24th

MID-WINTER

Clinical Conference

Dr. William McMillan Jr., chairman of the WVSMA Committee on Education, stresses a point at the breakfast for the Medical Education Committee.

Ibtesam Sue Barazi of OSHA was the guest speaker at the Young Physicians Luncheon.

Sports medicine was the topic of discussion at a special breakfast meeting chaired by Dr. David Avery.

Dr. Miraflor Khorshad was the lucky winner of two of the door prizes donated by exhibitors.

George Rider, WVSMA executive director, and Dee Crabtree, manager of WVSMA government relations, helped update members on recent activities at the West Virginia State Legislature.

Dr. John Huntwork, a new delegate in the West Virginia State Legislature, addressed Council members about his experiences during the current session.

WVSMA Auxiliary President Sara Townsend gave a report to Council members during their Mid-Winter meeting. Seated to her left is Dr. Robert Hess, AMA Alternate Delegate.

Dr. Robert D'Alessandri, dean of the WVU School of Medicine, and Dr. Charles McKown, dean of the Marshall School of Medicine, spoke to Council members about the financial problems at their institutions and the importance of medical education in the state. Council members passed a resolution to endorse and support funding requests for WVU and Marshall.

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Precautions:
- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

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Therapy-related adverse reactions are uncommon. Those reported include:
- Hypersensitivity reactions have been reported in about 1.5% of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of **serum-sickness-like** reactions have been reported with the use of Ceclor. These are characterized by findings of erythema multiforme, rashes, and other skin manifestations accompanied by arthritis/arthralgia, with or without fever, and differ from classic serum sickness in that there is infrequently associated lymphadenopathy and proteinuria, no circulating immune complexes, and no evidence to date of sequelae of the reaction. While further investigation is ongoing, **serum-sickness-like** reactions appear to be due to hypersensitivity and more often occur during or following a second (or subsequent) course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults with an overall occurrence ranging from 1 in 200 (0.5%) in one focused trial to 2 in 8,346 (0.024%) in overall clinical trials (with an incidence in children in clinical trials of 0.055%) to 1 in 38,000 (0.003%) in spontaneous event reports. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy; occasionally these reactions have resulted in hospitalization, usually of short duration (median hospitalization = two to three days, based on postmarketing surveillance studies). In those requiring hospitalization, the symptoms have ranged from mild to severe at the time of admission with more of the severe reactions occurring in children. Antihistamines and glucocorticoids appear to enhance resolution of the signs and symptoms. No serious sequelae have been reported.
- Stevens-Johnson syndrome, toxic epidermal necrolysis, and anaphylaxis have been reported rarely. Anaphylaxis may be more common in patients with a history of penicillin allergy.
- Gastrointestinal (mostly diarrhea): 2.5%
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1% and, rarely, thrombocytopenia and reversible interstitial nephritis.

Abnormalities in laboratory results of uncertain etiology.
- Slight elevations in hepatic enzymes.
- Transient lymphocytosis, leukopenia, and, rarely, hemolytic anemia and reversible neutropenia.
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Electrophysiologic Studies: Recent Experience at the Charleston Area Medical Center

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Abstract

Electrophysiologic studies (EPS) were performed in 122 patients for evaluation of supraventricular tachycardia (16 patients), syncope (30 patients), ventricular tachycardia (48 patients), sudden cardiac death (7 patients), and other reasons (21 patients). Sixty patients had an induced sustained supraventricular and/or ventricular arrhythmia. Therapy was rendered to all 60 patients based on the results of the EPS.

The evaluation and treatment of supraventricular and ventricular arrhythmias is assisted by EPS. The capability of inducing the clinical arrhythmia, determination of the arrythmia mechanism, and evaluation of the response to various pharmacologic agents improves therapeutic choices. Patient morbidity from cardiac arrhythmias is thereby reduced.

Introduction

Electrophysiologic studies have been used to evaluate patients presenting with a variety of documented and presumed cardiac rhythm disturbances. While many of these disturbances can be managed without such an evaluation, certain of these may be associated with significant symptoms such as presyncope, syncope, or death. In most instances, these symptoms are related to a tachyarrhythmia rather than a bradyarrhythmia (1,2).

Supraventricular tachyarrhythmias are infrequently associated with syncope and rarely with death. Empiric pharmacologic treatment is successful in most cases. However, if the tachycardias are associated with significant symptoms or if the episodes of tachycardia are frequent despite medications, then electrophysiologic and pharmacologic testing should be considered (3). If non-pharmacologic treatment (i.e. catheter ablation, arrhythmia surgery, or antitachycardia pacing) is anticipated, electrophysiologic evaluation is required.

Malignant ventricular arrhythmias (4) occurring outside the setting of an acute myocardial infaction, drug toxic reaction, electrolyte imbalance, or other reversible cause, usually warrant electrophysiologic evaluation. The purposes of such an evaluation are for selection of therapy (pharmacologic and non-pharmacologic), confirmation that the arrhythmia is ventricular in origin, and prognostic evaluation (5). Furthermore, the selection of antiarrhythmic drug therapy by electrophysiologic testing has been shown to predict efficacy and favors a decreased incidence of arrhythmia recurrence (6).

The following is a review of recent experience in electrophysiologic testing at the Charleston Area Medical Center (CAMC). All electrophysiologic studies were performed between October 1989 and September 1990.

Patients

Patients were referred to the cardiac arrhythmia service at CAMC for evaluation of a documented cardiac rhythm disturbance or symptoms suggesting the presence of an arrhythmia. All patients underwent physical examination and appropriate laboratory testing which in some patients included cardiac catheterization, echocardiography, signal-averaged electrocardiography, or tilt table testing.

One hundred sixty-four electrophysiologic studies were performed in 122 patients for evaluation of supraventricular tachycardia (16 patients), recurrent syncope (30 patients), ventricular tachycardia (48 patients), sudden cardiac death (7 patients), implantable cardioverter defibrillator function testing (15 patients), wide QRS tachycardia (3 patients), and heart block (3 patients). Eight patients underwent 2 or more electrophysiologic studies.

Sixty patients had a sustained ventricular and/or supraventricular arrhythmia induced at electrophysiologic study. A sustained ventricular arrhythmia (ventricular tachycardia 41, ventricular fibrillation 4) was induced in 45 patients. This group of patients included 40 patients with coronary artery disease (defined as greater than 50 percent luminal coronary narrowing), four patients with a dilated cardiomyopathy, and one patient with no structural heart disease. The mean age of the patients was 64 ± 9 years (range 42 to 80 years). There were 35 males and 10 females. The mean left ventricular ejection fraction measured 0.34 ± .1 percent (range 0.2 percent to 0.6 percent). The history of a previous (3 or more weeks prior to electrophysiologic testing) myocardial infarction was present in 24 patients. A left ventricular aneurysm (3 anterior, 1 inferior) was present in 4 patients. Patients having induced sustained ventricular arrhythmias are listed in Table 1.

Twenty-three patients had a supraventricular tachycardia induced. There were 8 males and 15 females. Thirteen of these patients had no structural heart disease. Coronary artery disease was present in 6 patients, 1 patient had mitral

TABLE I
Patients and Induced Sustained Ventricular Arrhythmias

male/female	35/10
age	64 ± 9 years
heart disease	
coronary	40
* other	5
history of MI	24
LV aneurysm	4
Induced arrhythmia	
VTsm	41
RBBB	21
LBBB	11
indeterminate	5
VF	4
Response to drugs	
procainamide	4/37
procainamide/lido	0/12
quinidine	0/2
esmolol	0/2

Legend

* — dilated cardiomyopathy (4 patients), no structural heart disease (1 patient)
LBBB—left bundle branch block morphology
RBBB—right bundle branch block morphology
VTsm—sustained monomorphic ventricular tachycardia
VF—ventricular fibrillation
lido—lidocaine

valve prolapse, and 1 patient had mitral regurgitation.

Electrophysiologic Testing

Each study was performed in the fasting state and with antiarrhythmic drugs being held for 48 hours or five drug half lives. Two or three multipolar pacing catheters were passed percutaneously via the right femoral vein and were positioned at the high lateral right atrial wall, just across the tricuspid valve in the region of His bundle, and at the right ventricular apex. Intraveneous heparin (3,000-5,000 units) was then given. Programmed stimulation of the atrium consisted of 8 paced beats at 100 bpm with a single extrastimulus being introduced and decremented to atrial refractoriness. Atrial, atrioventricular nodal, and His Purkinje tissue refractory periods were thus determined. Sinus node recovery times, and, in some cases, sinoatrial conduction were assessed. The response to carotid sinus massage was also determined. Catheter recordings and mapping of the right atrium and coronary sinus were carried out in patients having accessory pathways, using previously described methods (7).

Programmed stimulation of the right ventricle was performed initially at the right ventricular apex and consisted of 8 paced beats at 100, 120, and 150 bpm with single and double extrastimuli being introduced. If no sustained ventricular arrhythmia was induced, the same protocol was repeated at the right ventricular outflow tract. Finally, three extrastimuli were introduced if up to two extrastimuli introduced at two ventricular sites did not induce a sustained ventricular arrthymia.

Additionally, further attempts to induce an arrhythmia were by left ventricular programmed stimulation (1 patient), isoproterenol (Isuprel) infusion (1 to 5 ug/min, 3 patients), and programmed stimulation using implanted permanent pacemakers (6 patients) with pacing methods as previously described.

Three intracardiac electrograms and surface leads (I, aVf, and V1) were recorded using a physiologic recorder. A sustained monomorphic ventricular tachycardia was defined as one having a uniform morphology in all three surface leads and lasting longer than 30 seconds, or lasting less than 30 seconds but requiring termination due to hemodynamic compromise.

Laboratory drug testing was carried out after reproducible induction of a supraventricular or ventricular arrhythmia.

Patients were given loading doses of intraveneous procainamide (Pronestyl) (10 to 15 mg/kg), lidocaine (2 to 3 mg/kg), quinidine gluconate (4 to 10 mg/kg), verapamil (Calan) (5 to 10 mg total dose), adenosine (Adenocard) (6 to 30 mg total dose), or esmolol (Brevibloc) (500 ug/kg loading and 50 to 150 ug/kg/min maintenance). Serum levels of procainamide, lidocaine, and quinidine were drawn at the completion of a study.

Results

Sustained monomorphic ventricular tachycardia was induced in 41 patients. The induction of this ventricular tachycardia required one ventricular extrastimulus in 1 patient, two extrastimuli in 23 patients, three extrastimuli in 15 patients, and a burst of ventricular extrastimuli in 2 patients. The mean ventricular tachycardia rate was 204 beats/minute (range 142 to 300 beats/minute).

Ventricular tachycardia QRS morphologies observed included 21 right bundle branch block, 11 left bundle branch block, and five indeterminate patterns. Multiple QRS morphologies occurred in eight patients. Ventricular tachycardias were terminated by pacing in 19 patients (46 percent) and electrical cardioversion in 19 patients (46 percent). Spontaneous tachycardia termination occurred in 3 patients (7 percent) of the 32 patients known to have had sustained ventricular tachycardia clinically, 30 (93 percent) had their tachycardia induced at electrophysiologic study. Twenty-seven of 28 patients (96 percent) with coronary artery disease and a known history of sustained ventricular tachycardia had their tachycardia induced at electrophysiologic study, while 3 of 4 patients (75 percent) with a dilated cardiomyopathy had their tachycardia induced.

Ventricular fibrillation was induced in 4 patients who had coronary disease. Severly impaired left ventricular function was present in three patients and a normal left ventricle in one patient. Two patients had been resuscitated from sudden cardiac death; one patient had exercise induced ventricular fibrillation, and the remaining patient had spontaneous ventricular fibrillation (structurally normal left ventricle).

Five patients having an induced sustained ventricular tachycardia did not have coronary artery disease. Four of these patients had a dilated cardiomyopathy. One patient with a structurally normal heart had a sustained ventricular tachycardia that was only inducible following isoproterenol infusion.

Drug testing (Table 1) revealed acute ventricular tachycardia suppression in four of 37 patients (10.8 percent). Eight patients did not undergo acute drug testing. The mean rate of the induced ventricular

tachycardia after drug testing was 162 beats/minute (compared with a mean rate of 204 prior to drug testing). Procainamide was tested in 29 patients and prevented tachycardia reinduction in 4 patients (13.7 percent). The mean procainamide serum level achieved was 7.8 q ± 2 mg/L (range 3.9-12.4).

Lidocaine was tested in combination with procainamide in 12 patients and in no patient was it tested alone. This drug combination did not prevent tachycardia reinduction in any of the patients. The mean serum lidocaine level achieved at the administered doses measured 5 q ± 2 mg/L (range 1.7-10). Quinidine and esmolol were tested infrequently and did not prevent the reinduction of ventricular tachycardia when tested.

Those patients failing acute and follow-up drug testing on conventional antiarrhythmic drugs were placed on oral amiodarone, or received a cardioverter defibrillator, or both. Long-term drug therapy for patients with complete drug suppression of ventricular tachycardia included procainamide (2 patients) and mexiletine and quinidine in combination (1 patient). Antiarrhythmic drug therapy in the remaining patients included amiodarone (25 patients), procainamide (6 patients), mexiletine (3 patients), and mexiletine and procainamide (1 patient). This latter group of patients included those receiving a cardioverter defibrillator and those not having complete suppression, but significant slowing of the tachycardia in response to drugs.

Two of the patients having a left ventricular aneurysm underwent cardiac surgery. However, operative mapping was performed in only one patient. This patient had a discrete left ventricular apical aneurysm with easily induced and hemodynamically stable ventricular tachycardia. The endocardium was mapped during ventricular tachycardia with subsequent subendocardial resection (8) and cryoablation (9) of the tachycardia focus. A cardioverter defibrillator was also implanted. A tachycardia could not be induced immediately after the resection or 1 week later.

Cardioverter defibrillators were implanted in a total of 17 patients for recurrent drug refractory sustained ventricular tachycardia (12 patients) and sudden cardiac death (5 patients). Three of these patients also had pacemakers implanted, one of which was an antitachycardia pacemaker.

The follow-up for patients having an induced sustained ventricular arrhythmia is 6.4 ± 3 months (range 1-12). Two deaths occurred. One death was related to heart failure and the other was sudden, a 69-year old male with induced ventricular drug refractory tachycardia who refused cardioverter defibrillator implantation and was, therefore, placed on amiodarone.

A supraventricular tachycardia was induced in 23 patients (Table 2). Syncope had occurred in four patients and presyncope in 1. Thirteen patients had an accessory pathway. Left-sided accessory pathways were present in 9 patients, four of which were concealed. Also found were posteroseptal (1 patient), right anterior (1 patient), and nodoventricular accessory pathways (2 patients). The accessory pathway was involved in the supraventricular tachycardia mechanism in all of these patients. Three patients were sent for surgical division of the accessory pathway because of a rapid ventricular rate during induced atrial fibrillation (2 patients) and the desire not to take antiarrhythmic medications (1 patient). Antitachycardia pacemakers were implanted in two patients with concealed accessory pathways. The remaining eight patients were managed with antiarrhythmic drugs including procainamide, verapamil, atenolol, propafenone, and low-dose amiodarone.

Catheter ablation of the atrioventricular node (10) was performed in a patient with a dilated cardiomyopathy with recurrent drug refractory atrial flutter and associated heart failure. Complete heart block was rendered subsequently, and three days later this patient underwent permanent pacemaker implantation.

One patient with coronary artery disease and severe left ventricular dysfunction presented with recurrent ventricular tachycardia. Electrophysiologic testing revealed inducible drug refractory ventricular tachycardia. This patient was not a candidate for an operative procedure. He, therefore, underwent left ventricular catheter mapping and was considered for catheter ablation of the site of origin of the ventricular tachycardia. However, five different ventricular tachycardia morphologies were noted during the study. Multiple ablation shocks would have been required to eliminate the tachycardias so the patient was instead placed on amiodarone.

Discussion

While the initial use of an electrophysiologic study was primarily for the evaluation of

TABLE 2
Induced Supraventricular Arrhythmias

Reciprocating tachycardia		13	
	left sided	9	surgery 2, D, F, V, B, pm
	right sided	1	B
	posteroseptal	1	surgery
	nodoventricular	2	A, B
AV nodal reentry		5	D, pp, V
Sinus node reentry		1	Q
Intraatrial reentry		1	P
Atrial fibrillation/flutter		3	P,C

Legend: A - amiodarone, B - beta blocker, C - catheter ablation, D - disopyramide, F - flecainide, pm - antitachycardia pacemaker, pp - propafenone, P - procainamide, Q - quinidine, V - verapamil.

arrhythmia mechanisms, subsequent reports revealed its utility in the selection of antiarrhythmic drug therapy (11), the assessment of prognoses in patients having malignant ventricular arrhythmias (12), and evaluation for non-pharmacologic treatment modalities (such as implantable antitachycardia devices (13), catheter ablation (14), and map-guided arrhythmia surgery.

In this report, 45 patients had an induced sustained ventricular arrhythmia, however, successful drug therapy was selected acutely in only four of 37 patients (10.8 percent). This is consistent with impaired left ventricular function being found to be associated with a poor response to antiarrhythmic drug therapy (15). Treatment in these patients usually is by oral amiodarone or non-pharmacologic means. The mean ejection fraction of the 4 patients responding to acute drug testing was 0.43 ± .11 percent and slightly better than the remaining group of patients.

Patients who failed acute drug testing received oral amiodarone or an implanted cardioverter defibrillator depending on the individual patients clinical presentation. Amiodarone has found widespread use in the management of malignant ventricular arrhythmias due to its demonstrated efficacy. In a review of 462 patients with malignant ventricular arrhythmias being treated with amiodarone, Herre, et al, reported a 9 percent and 15 percent recurrence rate of sudden cardiac death at 1 and 3 years, respectively. However, after 1 year, 45 percent of patients had developed side effects and discontinuance of amiodarone was required in 14 percent (16).

Certain non-pharmacologic treatment modalities have been reported to be associated with significantly improved survival in patients with malignant ventricular arrhythmias. Hargrove, et al, reported a 94 percent survival rate at 1 and 2 years in patients undergoing map-guided arrhythmia surgery (17). Additionally, the survival was 100 percent at 3 years in 77 patients who had undergone cardioverter defibrillator implantation.

The role of catheter ablation in the management of malignant ventricular arrhythmias has been limited to patients with recurrent drug-refractory arrhythmias which may be incessant or associated with relative patient contraindications for an operative procedure. A hemodynamically-stable ventricular tachycardia is required to facilitate catheter mapping and localization of the site of origin of the tachycardia. Multiple ventricular tachycardia morphologies may decrease the success rate of catheter ablation (18). Success rates for this procedure have been in the range of 50 percent to 80 percent (19).

The majority of patients referred for evaluation of symptomatic supraventricular tachycardia had an accessory pathway. Most of these pathways were located on the left side of the heart, as is the usual case. In four of 13 patients with accessory pathways, there was no EKG evidence of the Wolf-Parkinson-White syndrome consistent with the presence of a concealed accessory pathway. The most common tachycardia mechanism involved antegrade conduction down the atrioventricular conduction system with retrograde conduction up the accessory pathway (orthodromic reciprocating tachycardia).

Patients with Wolf-Parkinson-White syndrome may rarely experience sudden arrhythmic death due to the occurrence of atrial fibrillation with rapid antegrade conduction across the accessory pathway. This may drive the ventricles to the point of fibrillation. Risk factors for such an occurrence are the administration of digoxin or verapamil as a treatment for this type of atrial fibrillation, the presence of multiple accessory pathways, and the presence of an accessory pathway that conducts antegrade very rapidly during atrial fibrillation. Esophageal pacing, standard exercise testing, and intravenous procainamide have been used to assess a patient's risk for developing rapid atrial fibrillation and subsequent death. However, some investigators believe that all symptomatic patients with Wolf-Parkinson-White syndrome should undergo invasive electrophysiologic testing for risk assessment (20).

The management of supraventricular arrhythmias by catheter ablation of the atrioventricular node has been reported for atrial flutter and fibrillation, atrioventricular nodal tachycardia, and ectopic atrial tachycardias (21). Subsequent permanent pacemaker implantation is usually required, however, modification rather than disruption of the cardiac conduction system may be rendered with subsequent control of the tachycardia, but elimination of the need for pacemaker implant. Recently, success has been reported for radiofrequency catheter ablation of tachycardias utilizing an accessory pathway (22).

Although recognized as a diagnostic tool, electrophysiologic techniques have recently played a greater role in the therapy of cardiac arrhythmias. Future developments in electrophysiology will bring forth a greater understanding of arrhythmia mechanisms and a more widespread use of device therapy for the management of complicated cardiac arrhythmias.

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Fibromyalgia in Children; Diagnosis and Treatment

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Abstract

Fifteen children (16 years and younger, 10 females, 5 males, mean age 13 years) with juvenile primary fibromyalgia syndrome (JPFS) were seen in a private rheumatology practice over two years. This represented 45 percent of the total number of pediatric rheumatology patients. Symptoms included polymyalgias, polyarthralgias, non-restorative sleep, difficulty concentrating in school and fatigue. Examination revealed typical tender points, absence of joint swelling, synovitis or nodules and absence of neurological findings. Dolorimetry was abnormal and standard laboratory tests were normal.

Most of these patients (67 percent) had seen three or more doctors prior to their rheumatological evaluation and not (60 percent) were told they had juvenile chronic arthritis. Other diagnoses offered were "growing pains" (20 percent), hysteria (7 percent) and psychological problems (7 percent). None of the JPFS patients responded to salicylate or other anti-inflammatory medication. Most (73 percent) responded to cyclobenzaprine, mean dose 12.75 mg. (range 5-25 mg. qhs).

JPFS is a very common pediatric rheumatologic problem and is confused with other disorders. Reassurance is very important in the therapy since many parents are fearful that their children may have a potentially crippling disorder. Medication, especially with tricyclics, moderate exercise and proper sleep are also mainstays of therapy.

Introduction

Musculoskeletal pain is a very common presenting symptom. The primary care physician sees adults and children with this problem on a daily basis. Most cases are due to an acute, readily-identifiable insult (e.g. trauma, viral illnesses, etc.) and the diagnosis and management are usually straightforward. However, chronic musculoskeletal pain whose etiology is unknown and for which no diagnosis "fits" is always a cause for concern. It is especially worrisome if the patient is a child since children may not be able to articulate their symptoms as well as adults. The primary care physician also needs to "treat" the parents who understandably may be anxious and apprehensive, often fearing that their children may be crippled or otherwise permanently affected by the disorder.

Juvenile primary fibromyalgia syndrome (JPFS) is a relatively common but newly-described disorder. It affects children by causing diffuse musculoskeletal pain, stiffness and fatigue but fortunately does not cripple (1). In order to assess the frequency of this disorder in a general rheumatology practice and learn the best means of treating JPFS, all pediatric charts over a two-year period (January 1, 1987 to December 31, 1988) were reviewed. This study demonstrates that JPFS is a common and readily treatable disorder.

Patient Population

Over a two-year period, 33 pediatric patients (16 years of age or younger) were studied. There were 23 females and 10 males with a mean age of 12 years. The distribution of diagnoses is shown in Table 1.

Of the patients with JPFS, five were male and ten were female. Mean age was 13 (12 for males, 14 for females). The diagnosis of JPFS was made using criteria adapted from Yunus and Masi (1) as shown

TABLE 1
The Distribution of Diagnoses of the 33 Pediatric Patients Studied

	Number	*Mean Age*
Juvenile Primary Fibromyalgia (JPFS)	15	13 yrs.
Juvenile Rheumatoid Arthritis (JRA)	10	11 yrs.
Hypermobility Syndrome	2	8 yrs.
Septic Arthritis	2	8 yrs.
Systemic Lupus Erythematosus	2	9 yrs.
Raynaud's disease	2	8 yrs.

TABLE 2
Criteria for JPFS*

1. Presence of diffuse musculoskeletal aches, pains and stiffness for at least three months.
2. Presence of at least ten typical and discrete tender points.
3. Symptoms modulated by such factors as weather, physical activity, and anxiety/stress.
4. Non-restorative sleep.
5. Absence of arthritic, inflammatory, endocrine or infections processes.
6. Normal standard laboratory tests. **

* Adapted from Yunus, MB, Masi AT. Arthritis Rheum. 1985; 28:138-145.

** With the exception of low titer Antinuclear Antibody (ANA).

TABLE 3
Percent Frequency of Symptoms in JPFS Patients

Symptom	*Percent in JPFS Patients*
Musculoskeletal	
Diffuse pain	100%
Stiffness	67%
Subjective soft tissue swelling	33%
Systemic/general	
Fatigue	100%
Poor Sleep/waking up tired	73%
Headaches	53%
Numbness/tingling	33%
Anxiety	33%

in Table 2. All 15 patients also satisfied criteria for fibromyalgia syndrome (FS) that were formulated and published after this study was completed (2). In addition, all 15 JPFS patients had abnormal dolorimetry which showed a pattern consistent with FS.

The frequency of symptoms in the JPFS patient population is shown in Table 3. Diffuse musculoskeletal pain was present in all patients and stiffness (67 percent) and complaints of soft tissue swelling (33 percent) were also present. Most of the patients complained of fatigue (100 percent), poor (i.e. non-restorative) sleep (73 percent), and headaches (53 percent). The technique of dolorimeter testing is amply explained in a previously-published study (3). Briefly, a dolorimeter is a pressure algometer that provides the examiner with a way to quantitate tenderness over anatomic sites. The frequency distribution of myofascial tender points in the 15 JPFS patients in this study is compared with that of Yunus and Masi's patients (Table 4). They are very similar, suggesting that the application of diagnostic criteria was uniform in both studies. Standard laboratory tests were normal in the JPFS patients with the exception of three patients with positive anti-nuclear antibody (ANA). All were low titer (1:40), one ANA had a speckled pattern, and the other two had homogeneous patterns. Anti-DNA testing was negative in all cases, as were repeat ANAs.

Treatment

Once the diagnosis of JPFS was firmly established, treatment was intiated. Counseling of the parents was of paramount importance. Many parents (60 percent) had been told that their children had arthritis causing much concern and anxiety as well as subsequent confusion when the diagnosis of JPFS was made. Other patients had been told they had "growing pains" (20 percent), hysteria (7 percent) or psychological problems (7 percent). Most of the JPFS patients (67 percent) had seen three or more doctors prior to their rheumatological evaluation.

Once the children (and their parents) had been reassured and educated about JPFS, pharmacologic treatment was given. None of the JPFS patients had previously responded to salicylates or non-steroidal anti-inflammatory drugs in the past, so this strategy was not pursued. Since the treatment of FS frequently involves the use of tricyclic anti-depressants (4-6) and since cyclobenzaprine (Flexeril) had

TABLE 4
Frequency Distribution of Tender Points

Site	*Yunus & Masi Study* (33 patients)	*Present Study* (15 patients)
Medial Knee	76%	70%
Greater Femoral Trochanter	15%	28%
Trapezius	82%	68%
Rhomboid	24%	30%
Second Rib	39%	45%
Sacroiliac Area	45%	40%
Occiput	58%	67%
Lat. Humeral Epicondyle	67%	67%
Med. Humeral Epicondyle	55%	45%
Thoracic Spine	36%	28%
Sternocleidomastoid	61%	55%
Post. Iliac Crest	39%	40%
Gluteus Medius	15%	20%
	Mean No. Tender Points: 12 31 white 2 black	Mean No. Tender Points: 14 All white

TABLE 5
Treatment Response (All 15 Children Experienced a Therapeutic Response)

Number	*Medication (Dose)*
2	Cyclobenzaprine HCl (5.0 mg)
1	Cyclobenzaprine HCl (7.5 mg)
5	Cyclobenzaprine HCl (10 mg)
3	Cyclobenzaprine HCl (≥ 15 mg)
2	Amitriptyline (25 mg)
1	Trazodone (50 mg)
1	L-Tryptophan (1,000 mg)
15	**Total Patients**

both direct muscle relaxing properties as well as being a tricyclic agent with efficacy in FS (7), all JPFS patients were started on 10 mg. of cyclobenzaprine (Flexeril) at bedtime. The dose was either raised (i.e lack of efficacy) to 25 mg. in increments of 2.5 mg. or lowered (e.g. side effects such as morning grogginess or anti-cholinergic effects).

A favorable response to treatment consisted of (1) subjective report of fewer symptoms, (2) reduction of tender points by at least 50 percent, and (3) improved sleep (i.e. reduction in the number of night-time awakenings by 50 percent or the attainment of the sensation of waking up refreshed 50 percent more than prior to treatment). Most JPFS patients (73 percent) responded to cyclobenzaprine but the doses needed for a therapeutic response varied (Table 5). Some patients (20 percent) experienced morning grogginess and the dose had to be decreased to 5 mg. qhs. Other patients (33 percent) responded well to 10 mg. qhs. Still others (20 percent) needed higher doses up to 25 mg. qhs. Of the four patients (27 percent) in whom cyclobenzaprine was ineffective, two patients got relief with amitriptyline (Elavil 25 mg. qhs). One patient responded to Trazodone (Desyrel 50 mg. qhs). Another obtained a good response with 1,000 mg. L-Tryptophan, having been unable to tolerate the three medications already mentioned. The use of L-Tryptophan is no longer encouraged because of the recent reports of eosinophil-iamyalgia syndrome (EMS) linked to certain L-Tryptophan preparations (8). When L-Tryptophan was stopped in the patient, JPFS symptoms did not recur and he remains clinically improved.

Discussion

A surprising 45 percent of the total number of pediatric rheumatology patients studied over a two-year period in my general rheumatology practice had JPFS. This finding is in-line with the observation that in adults FS is very commonly seen (9).

Most of the JPFS patients complained of fatigue and parents complained that their sleep was fitful and restless. Cyclobenzaprine, is remarkably similar in chemical structure to amitriptyline, and was helpful in correcting the sleep problem in most JPFS patients. An added bonus in using cyclobenzaprine for these children is that cyclo-benzaprine is a "muscle relaxant" not an "anti-depressant" thus obviating any possible stigma associated with the treatment. This medication is not associated with gastrointestinal toxicity as are the non-steroidal anti-inflammatory drugs which are relatively ineffective when used in the treatment of FS (5). One of the dangers of not being aware of the existence of JPFS is exposing patients to toxicity from a class of medications that may not be the ideal therapeutic choice. Another danger is the tendency to form a lengthy and occasionally invasive work-up in an effort to try to explain the numerous and often confusing array of symptoms encountered in JPFS patients.

JPFS is a common but often overlooked rheumatologic condition that is frequently confused with other problems, especially juvenile rheumatoid arthritis (JRA). It is important to recognize this condition in order to avoid unwarranted investigation and improper management. The treatment of JPFS is usually effective and well tolerated.

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Self-Mutilation Resulting in Bacterial Meningitis

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Abstract

Self-mutilation and particularly self-destructive dermatoses are not usually life-threatening. This case involves a man who met the DSM-III R diagnostic criteria for delusional (paranoid) disorder, somatic type. His destructive behavior involving the face and scalp resulted in osteomyelitis and pneumococcal meningitis. He responded to treatment initially, but was later lost to follow-up. No similar case of self-mutilation has been reported.

Figure 1. Significant scarring was present below the eye line. The patient later reported having removed 70 "projectiles" on the lower half of his face and had begun working on the upper 70.

Introduction

Self-mutilation by mentally-retarded or psychiatrically-ill people is usually more disfiguring than life-threatening. Enucleation, castration and amputation are less common and more life-threatening types of self-mutilation. In this case, a piece of skull was removed which resulted in life-threatening pneumococcal meningitis. This type of self-mutilation and the delusion involved removing "projectiles" has not been previously described. This patient met diagnostic criteria for delusional (paranoid) disorder, somatic type, as defined by DSM-III-R (1).

Case Report

A 58-year-old man was found in a car by police and brought to the hospital. His temperature was 39.4°C. Meningismus was present, but there were no focal neurologic signs. Multiple keloidal scars of the lower part of the face associated with encrusted erosions were noted. The scars were initially felt to be the residual of a burn injury (Figure 1).

Most remarkable was a 3 x 6 cm, deep ulcer on the apex of the skull covered by a thick necrotic appearing area. Three smaller necrotic ulcers were in the same area. Skull films revealed a skull defect to the left of the midline in the fronto-parietal region. Non-contrasted CT of the head revealed the bony defect and subdural air (Figure 2). The opening pressure upon lumbar puncture was 420 mm H_2O. The cerebrospinal fluid revealed a glucose of 5 mg percent, total protein 542 mg percent, white blood count of 1500 cu mm with 90 percent polymorphonuclear leukocytes. Streptococcus pneumoniae grew from cerebrospinal fluid cultures.

The patient became alert in a few days. The necrotic scalp lesions were suspicious for basal cell carcinoma, but multiple biopsies showed granulation and necrotic tissue. The skull defect was not felt to be neurosurgical in origin. The story gradually evolved. The patient had picked at his face and scalp to remove "projectiles." The picking had gone on for some time leading to severe scarring of the face (Figure 1).

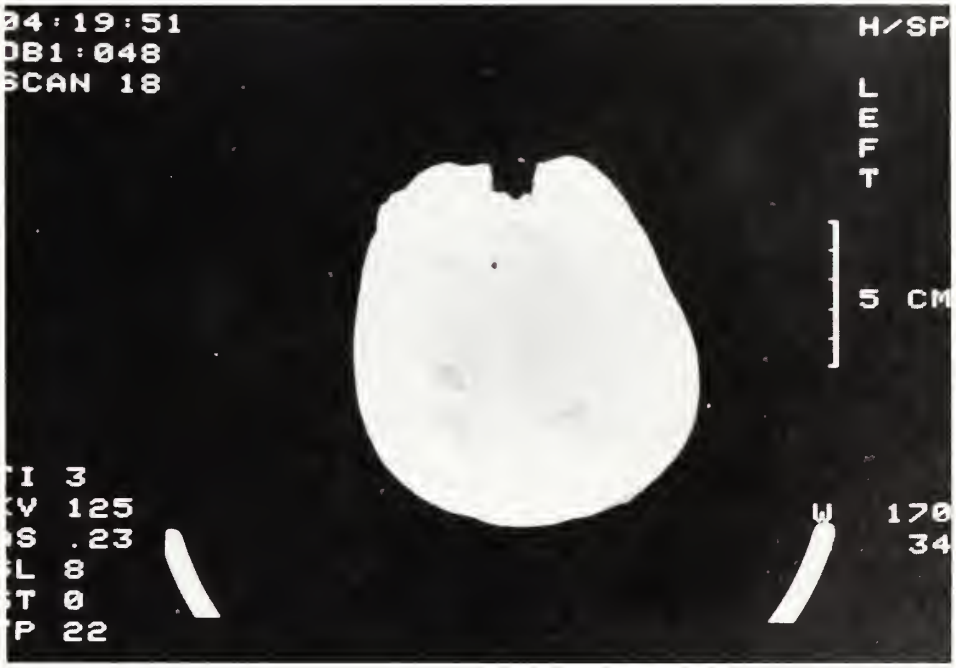

Figure 2. CT film showing frontal bony defect and a small amount of air near the midline.

He had worked extensively on his scalp, using a black hair dye which may have contributed to the necrotic appearance of the scalp wounds. He reported, "I have removed gristle out of my scalp." It is presumed that osteomyelitis of the skull developed allowing him to remove a piece of bone. He described feeling a spongy area below the area from which he had removed the "gristle." Fortunately, he suspended further exploration.

He was treated for pneumococcal meningitis and osteomyelitis of the skull and was given haloperidol because psychiatric consultants felt he had a systemized delusional thinking. The scalp lesion healed well, and he agreed not to irritate the area further. Accommodations were obtained at a men's shelter. Outpatient follow-up was uneventful for two months on a modest dose of haloperidol. However, he discontinued the medication and left the shelter. He returned intermittently for follow-up and had again begun picking at his face and less so at the scalp. Haloperidol decanoate injection was tried, but he was lost to follow-up.

Discussion

In past centuries, trephination of the skull has been practiced on those suffering from mental illness to allow evil spirits or humors to exit (2). Self-trephination was not intentional in this case. Delusory parasitosis is well described with afflicted persons supplying scabs, scales, lint, and even cutaneous nerves as evidence of infestation (3). Some individuals heve delusions of an inanimate habitation of their body (4). No reports in the literature of projectiles, missiles or bullets in the skin were discovered.

Explanations and diagnoses for self-mutilation are quite varied. In very destructive examples, schizophrenia figures strongly (2, 5). People with paranoid psychoses may feel that alien forces such as electricity, X-rays, or atomic radiation are aimed at them (3). Delusions of infestation span all diagnostic categories and have been associated in schizophrenia with a higher incidence of suicide. Delusions of persecution may involve family, occupational, or sexual relationships (6). Occasionally, delusions may be organic in etiology. Delusions occur with alcoholism, drug addiction, and Vitamin B^{12} deficiency.

The self-destructive dermatoses are much more likely to trouble females (7). Waisman felt that the scalp which was not covered by hair was more often selected for attention by males (3). The prognosis in the self-destructive dermatoses is unpredictable, and a favorable outcome may depend upon social or family changes. Many or most self-destructive dermatoses will present to dermatologists and the patient can be resistant to referral for psychiatric consultation (8). Pimozide has been used with greater success than other neuroleptics in one study (8). In the case discussed, the patient initially felt that all the projectiles had been removed and reported he felt no need to continue digging.

Conclusion

Dermatologic abuse involving psychosis has many presentations, though infestation is most often commonly involved. A case of self-destructive dermatosis which involved removal of a piece of skull and subsequent bacterial meningitis is reported. A systemized delusion of projectiles underneath the facial and scalp skin was the impetus for the patient's picking. He initially responded and was receptive to treatment but relapsed later. Such cases have been difficult to treat. He has since been lost to follow-up.

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Manuscripts to be presented for publication in the *West Virginia Medical Journal* should be prepared in accordance with "Uniform Requirements for Manuscripts Submitted to Biomedical Journals" (1) (International Committee of Medical Journal Editors).

The *West Virginia Medical Journal* will not consider for publication a paper or work that already has been reported in a published paper, or is described in a paper submitted or accepted for publication elsewhere.

Manuscripts, accompanied by one copy, should be typewritten, double-spaced, on one side only of white bond paper (8½ by 11 in.), with margins of at least one inch.

Use double spacing throughout, including (in the following order) title page, abstract, text, acknowledgements, references, tables, and legends for illustrations. Begin each of the following sections on separate pages: title page, abstract, text, acknowledgements, references, individual tables, and legends for illustrations. Number pages consecutively, beginning with the title page. Type the page number in the upper right-hand corner of each page.

Articles contained on computer diskettes are acceptable and encouraged. Please contact the *Journal* in advance to determine the format type to be used. The conventional manuscript as described above must accompany the diskette.

All persons designated as authors should qualify for authorship. Each author should have participated sufficiently in the work to take public responsibility for the concept.

The second page should carry an abstract of no more than 150 words summarizing the manuscript.

Where reference is made to generically-designated drugs, the first such reference must be followed by parentheses containing the most commonly known trade-name drug of that designation. In addition, a listing of all generic drugs mentioned in the article, with their trade-name equivalents, should appear at the end of the article.

Tables (tabular listings) and figures (photos, drawings and charts) should be numbered and the point of reference in the text indicated in parentheses, i.e., (Table 1), (Figure 1).

Photos must be good-quality unmounted glossy prints usually 5 by 7 in. but no larger than 8 by 10 in. Black and white photos are preferred. Color photos will be printed in black and white. Cost of printing photos in excess of four will be billed to the author.

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Number references consecutively in the order in which they are first mentioned in the text. Identify references in text, tables, and legends by arabic numerals (in parentheses).

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Use the style of references seen in this *Journal*, which is based on the formats used by the U. S. National Library of Medicine in *Index Medicus*. The titles of journals should be abbreviated according to the style used in *Index Medicus*. Consult "List of the Journals Indexed," printed annually in the January issue of *Index Medicus*.

All scientific material appearing in the *Journal* is reviewed by the Publication Committee. Manuscripts should be mailed to The Editor, West Virginia Medical Journal, Box 4106, Charleston, WV 25364.

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President's Page

Michael M. Stump, M.D.

The Yellow Brick Road

On our way down the yellow brick road to the present decade we were guided by the political and social promise of everything for everyone at little cost. These unbounded promises by our leaders operating under deficit financing were followed by more such promises as the leaders discovered the path to their re-election. Their offerings were always greater than the demands of the people.

The counter voices of prudence and financial responsibility went unheeded. The "cradle to the grave" sociopolitical concept of taking care of all people, all the time, in all things, under all circumstances, grew accordingly. Older precepts of personal reliance and industry as well as individual responsibility and accountability began to fade in the face of apparently boundless resources and unlimited budgets.

Over the years, social welfare increased and expectations grew with scant restraint. Ultimately, people were conditioned to believe it normal to use deficit financing to continually borrow from the future for today's gain. Payback, if any, was for a future generation.

Thus, marveling at our brilliance, we embarked on our destiny toward the tragedy of scarce resources meeting unlimited promises and boundless demands.

In health care, we have now arrived at a point in time where medicine is told to bandage the errors of a faulty public policy. We are unfairly assaulted by restrictions, regulations and controls and condemned for the natural outcomes of defective public schemes. We are accused, when in fact, the faults lie with governments, legislatures and even society.

We are especially blamed for the bad health of those patients poorly prepared by government, legislative institutions and agents to live a productive healthy life. We are rebuked for poor access to health care or for the bad health of patients the government does not properly educate — for patients choosing not to contribute to themselves or society — for patients not properly taught a work ethic by family or society and who have not learned to hold a job and earn a living — for patients wanting to work but who cannot find the jobs that a sound system should offer — for patients harming themselves through lack of information or health knowledge — and for patients knowingly choosing to live unhealthily or follow lifestyles that induce illness. These patients are part of the care-rendering service and case load of any physician. We care for these patients daily and are not to blame for the conditions that brought them to their current status.

We now face the natural consequence of previous governmental actions and policies. We find that money and resources are limited and that promises and demands must be modified. Significant controls, regulations and fiscal restraints are today applied to patients as well as hospitals, physicians and various other providers. Government does not admit that anyone overpromised, or that past policy was in error, or that we have been wanton in our spending. In fact, if this were truly conceded or admitted, then we might be able to sit down and work out a reasonable and defensible policy that provides necessary health care and maintains the freedoms of our patients and our profession.

One of the greatest menaces of today's health policy, is the loss of some fundamentally important characteristics in the relationships among providers and between providers and patients. Under current severe constraints, these relationships are getting so strained that reasonable productive solutions are getting harder to come by. Relationships are becoming bitter and caustic. Hostility is increasing and becoming destructive.

At some point, we as a society must ask ourselves if what we are doing to our health care system by continuing the ever-increasing burdens of regulation and fiscal control is really what we want. At some point, we must remember that we are a unique people who have built certain characteristics into our health care that we are rapidly eroding and destroying. At some point, we have to let up before these fundamental American attributes are permanently impaired and lost forever.

Come let us reason together.

Michael M. Stump, M.D.

The High Cost of Immortality

Editor's Note: *This editorial was first published in the Journal in July 1971 and still remains very pertinent today.*

It isn't exactly true that we have immortality within our grasp. It is true, however, that every time death is driven back a step or two, we move in the direction of immortality. Indeed, death has been sent reeling and presently seems to stand vulnerable to the broadsword of medical research.

The ethical, moral, philosophical and even economic consequences of this imminent development are awesome. For some time physicians have been faced with the twin ethical and moral questions of how long we should keep a vegetating humanoid alive. The Church has helped to a degree—we are not morally required to employ heroic measures to prolong life in hopeless circumstances. It remains for us to determine what is hopeless and what is heroic. But what yesterday was hopeless is today not quite so hopeless, and what yesterday was heroic, is today commonplace.

Not too long ago, a cardiac arrest successfully dealt with made headlines; today, it causes barely a ripple in the ordinary routine of any busy general hospital. The medically unsophisticated might still be impressed and awed by intraveneous fluid administration but in all likelihood it is an unusual patient who manages to depart the hospital without the experience of having been "fed through my veins."

It has been relatively easy to make the decision to stop the IV's and the oxygen on someone hopelessly brain-damaged or cachetic and in agony with terminal cancer. A more difficult decision is which patient will have the available heart or kidney transplant or perhaps the artificial heart or the new dialysis machine. We will shortly have the technical capability of outfitting some human with a new set of plastic blood vessels, an artificial heart, handy portable renal dialysis machine and portable pulmonary blood oxygenator. Living might be cumbersome with such impedimenta but it will also very likely have possibilities of being lengthy.

There can be no argument that this will be a very expensive existence. The question of who will pay the medical expenses is an intriguing one. Will it be an H.M.O.? Medicare? A National Health Insurance Plan? What person or what committee will finally decree that it is just too expensive to keep this person alive? And what shall be the cutoff point medically and/or fiscally?

The point to be made is that as immortality is approached, medical costs tend toward infinity. Health planners along with Congress are struggling with facts, figures, actuarial tables, computers and, one might think, even crystal balls to establish projected costs for the various health plans. The truth of the matter is that if medicine is to be practiced to the fullest extent of its possibilities, there can be no cost limitations and no ceiling for total anticipated expenditures under any health plan.

If unlimited health care is to be given, health care cost will be unlimited. The type of health plan under which unlimited health care might be given would appear to be of very little consequence, for unlimited care would cost an unlimited amount of work, or time, or skill, or money under any plan.

These are not easy matters to contemplate or discuss. Our technical skills are creating social and moral problems as by-products of our medical successes. These problems must be dealt with by society as a whole rather than by the medical profession alone.

The conclusion appears simple enough: if medical costs are to be limited, medical care must be limited. Immortality comes dear. We probably cannot afford it. We will have to settle for just a bit of it.

—SDW

Medical Education Task Force Wrong

The recommendation of the Task Force on Medical Education does the wrong thing for the wrong reason and will have the wrong results for the people of West Virginia.

I was a practicing family physician in Lewisburg from 1980 until 1989 when I moved to Morgantown and joined the faculty of WVU School of Medicine. I did this because I understand the problems that physicians are having in this state and I felt I could have some impact on medical education and the practice of medicine in West Virginia.

From practicing in Lewisburg, I have knowledge of the Osteopathic School and I feel I understand its strengths and weaknesses. I have been exposed to the Marshall Medical School through my involvement with the West Virginia Family Practice Academy and the West Virginia Medical Association. I was trained at the WVU Medical School and at CAMC.

Each school provides completely different services and serves different needs. The idea of moving the Osteopathic School to Huntington shows a lack of understanding of the situation. The basic science program is the strongest aspect of the Lewisburg school. There is no significant clinical program there at all. To say that the Lewisburg school will be a rural health clinic and research center is asinine. It would require the development of a whole new institution in a rather sparsely populated area of the state which has excellent private medical facilities already available. The Osteopathic School is producing physicians for West Virginia at a relatively low cost and I feel it should be left alone. Its graduates should be encouraged to complete allopathic residences in the state. We have several primary care residency programs in West Virginia, many of which are having difficulty filling all their positions and osteopathic graduates should be encouraged to apply to these programs.

Marshall in my opinion is the least efficient and least productive of the three medical schools in terms of putting needed doctors in West Virginia. Although it plays a unique role by emphasizing practice in rural health centers and the use of allied health personnel (nurse practitioners, midwives etc.), these are functions of its clinical and residency programs. The basic science program there could be moved to Morgantown and the Huntington area could continue its clinical programs similar to the Charleston campus of WVU. This would replace duplication and the savings could be used to correct the funding shortfall at WVU, while preserving the Marshall school and Huntington's economy.

The WVU Health Science Center is by far the premier medical institution of the state. All rational studies have recommended that the funding and support for it could be increased. The Health Science Center's problem is that it has not done a good job of relating to the citizens of the state. I hope that the present crisis will correct this and that the school survives. There are definite advantages (academic, financial, prestige, geographic and convenience) to having it as part of the state land grant university. It would be a great disservice to all concerned to remove the Health Science Center from WVU.

The emphasis of the Legislature should be to improve the state's practice climate by enacting the legislation advocated by the West Virginia State Medical Association and the West Virginia Hospital Association, to stop the health professional brain drain from the state.

It appears to me that if the house is cold, it makes more sense to close the windows than to dismantle the furnace.

Stephen L. Sebert, M.D.
148 Lamplighter Drive
Morgantown, WV 26505

Special Correspondence

104 White Street, Apt. D
Charleston, WV 25302
February 14, 1991

Governor Gaston Caperton
Senate President Keith Burdette
House Speaker Chuck Chambers
Capitol
Charleston, WV 25305

Dear Sirs:

I am fourth-year medical student at West Virginia University, Charleston campus. I have followed with concern your efforts to reduce funding for West Virginia's medical schools. An article in the January 18 edition of the Charleston Daily Mail states that your reasons are as follows: "Caperton, Burdette and Chambers have said that West Virginia spends twice the national average on medical education yet doesn't have enough doctors. They are targeting WVU's medical school because they say it trains too many specialists who then leave the state instead of training doctors who will stay and help solve the state's health care crisis."

My classmates and I are those future doctors who are faced with the decision whether to stay or leave West Virginia and amidst all the uproar concerning medical education, no one has asked us why we are leaving. Instead you have arbitrarily elected to blame medical school training, and further confused the problem by throwing in the irrelevant issue of specialists vs. primary care physicians. West Virginia desperately needs all doctors, be they cardiology specialists or family practice physicians. Here is the real reason that young physicians are leaving, from the source, one of those future physicians.

I vividly remember the day two years ago when the Omnibus Health Care Act became law. As medical students, we were herded into the school auditorium and addressed by WVU Hospital President Bernard Westfall. He predicted that the law would have a devastating effect on medical care in West Virginia, and he was right. Within a week, four of my classmates, born and raised in West Virginia, who had every intention of practicing medicine in their home state, had made the decision to leave. That's four physicians, each with at least 35 years of medical care to give the state. That's 140 years worth of medical care. How many patient visits does that total? And these students were only four that I happened to speak with. I did not take a class poll. I did not ask the students in the other classes. I did not contact the students at the other two medical schools.

Why did these students make this decision? The Omnibus Health Care Act made West Virginia a most undesirable place in which to practice medicine. The many complex economic problems that pervade health care here were not addressed. Innovative solutions were not found. Instead this law made it more difficult for physicians to provide the quality care we're being trained to give, and further placed a greater burden on physicians to pay for the state's medical care out of their own pockets.

This mind set has continued unabated for the past two years. Today, the papers are again filled with bickering and squabbling on how to cut back funds for health care, how to make physicians shoulder more of the financial burden, how to cut back on medical education and further decrease the pool of future physicians for this state, and how to diminish the state-of-the-art patient care, facilities, and research at the medical complex in Morgantown. This last, in addition to providing free care for thousands of West Virginians, is a source of pride for medical professionals in West Virginia. It, along with the three medical schools, are the only two resources that BRING DOCTORS INTO OUR STATE.

West Virginia is not a good place to practice medicine. West Virginia is an adversarial place to set up a practice. The new physician immediately begins battle with the state and its health care economic policies. He or she struggles daily with how to provide good patient care for patients with little or no income, how to cover his or her own costs, including pay back of large educational loans, in a state where public resources can't or won't adequately supplement those patients too poor to pay.

That's what it boils down to, plain and simple, in the minds of today's medical students, tomorrow's physicians for West Virginia. The focus of medical training is not the reason young physicians leave West Virginia. You are the reason. You who have been given, by your constituents, those people who need the doctors, the resources to tap experts in the field for advice to solve these problems, and the power to enact the laws to make West Virginia a good place to practice medicine. You are doing just the opposite. You are chasing us out.

In three short months, I will become a physician, and will begin residency training in family practice. In three years, I will have the skills to provide the health care West Virginia desperately needs. I will graduate from medical school with debts over $70,000, the cost of my education. Over the past four years countless West Virginians have said to me, "Are you going to stay here to practice? We need you." And I would like to stay. Fortunately for West Virginia, I am not going to make this decision now. I am leaving my mind open to the possibility of practicing here. But in three years, when I will make that decision, the economic climate will be a major factor. If I had to make that decision today, West Virginia would have lost still another physician.

I could make a number of specific suggestions regarding things you could do to keep medical students interested in remaining in West Virginia to practice. I would be most happy to meet with you if you would like to discuss these ideas.

Sincerely,
Carol Costa

cc: WV Delegates, 23rd District
WV Senators, 8th and 17th Districts
Charleston Gazette
Charleston Daily Mail

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New 1991 Annual Meeting Format Created

At their recent meeting on January 26, the 1991 Program Committee for the WVSMA Annual Meeting changed the schedule for this year's conference to allow more time for House of Delegate activities.

According to Dr. Stephen Sebert, chairman of the Program Committee, time has not permitted the conclusion of business, particularly during the Saturday Second Session. This Second Session for the past two years, has interfered with the reception honoring the newly installed WVSMA officers and auxiliary leaders. The 1991 Annual Meeting will be held from August 14-17 at the Greenbrier in White Sulphur Springs.

A brief outline of the new meeting format is printed at right. If you have questions about the schedule, please contact Nancie R. Divvens at the WVSMA office, 925-0342.

1991 WVSMA Annual Meeting
August 14-17
The Greenbrier, White Sulphur Springs

New Program Format for 1991 Annual Meeting

PRE-CONVENTION MEETINGS

Tuesday, August 13

6 p.m.	WVSMA Executive Committee Meeting

Wednesday, August 14

9:00 a.m.	WVSMA Council Meeting

OFFICIAL PROGRAM

1 p.m.	Registration
1:30 p.m.	First Session House of Delegates
4:30 p.m.	Adjournment
6:30 p.m. - 7:30 p.m.	Presidential Reception

Thursday, August 15

8:30 a.m. - 2 p.m.	Registration
9 a.m.	FIRST GENERAL SESSION
Noon	Adjournment

Thursday Afternoon, August 15

1:30 p.m.	Committee on Resolutions
2 p.m.	Golf, Tennis, Volleyball Tournaments
3 p.m. - 6 p.m.	Third Generation Loss Control Seminar—First Half
6:30 p.m. - 7:30 p.m.	Reception

Friday, August 16

8:30 a.m. - 2 p.m.	Registration
8:45 a.m.	SECOND GENERAL SESSION
Noon	Adjournment
1 - 4 p.m.	Third Generation Loss Control Seminar—Second Half
4 p.m.	1992 Annual Program Committee Meeting
Noon - 3 p.m.	Breakout Section Meetings
6 p.m. - 7 p.m.	Alumni Receptions
9:30 p.m.	Entertainment

Saturday, August 17

8:30 a.m. - 10:30 a.m.	Delegate Registration
8:45 a.m.	Second Session House of Delegates
11:30 a.m.	Recess for Lunch
1 p.m.	Reconvene Second Session House of Delegates
4 p.m.	Adjournment
6:30 p.m. - 7:30 p.m.	Reception Honoring Newly Installed Officers of WVSMA and Auxiliary

Rockefeller, Caperton Speak at Wellness Summit

Senator Jay Rockefeller and Governor Gaston Caperton proclaimed West Virginia as "The Wellness State" at the first West Virginia Wellness Summit which was sponsored by the WVSMA at the Holiday Inn - Charleston House on Monday, January 28 in Charleston.

Health care professionals from throughout the state attended the conference to discuss wellness initiatives and make plans for an on-going wellness program to be established in West Virginia with community-based activities. The West Virginia Wellness Coalition, which is comprised of more than 20 different public and private organizations, was organized by the WVSMA last year when it became apparent that many groups were already working on wellness programs and that a coordinated approach was needed. The plans for the day-long summit grew out of this necessity to consolidate efforts on a state-wide basis.

"I am heartened and energized by these achievements, and hope that it is a sign of much better things to come," Senator Rockefeller said. "In the United States Senate, I will continue to take advantage of any and all opportunities to promote, improve and expand health care for West Virginians and all Americans."

Governor Caperton announced his health care agenda for 1991 which included plans to direct the West Virginia Health Care Commission to immediately address the areas of wellness and physical fitness of all children, perinatal care, early detection of senior citizens' health problems and networking local health services to focus on health promotion, preventive care and primary care.

After proclaiming West Virginia as "The Wellness State," Governor Gaston Caperton congratulated Dr. John Holloway, who was instrumental in helping to organize the Wellness Summit as chairman of the WVSMA Wellness Steering Committee.

Senator Jay Rockefeller praised all of the individuals and agencies responsible for the Wellness Summit and reaffirmed his commitment "to promote, improve and expand health care for West Virginians and all Americans."

Other speakers at the summit were John D. Holloway, M.D., chairman of the WVSMA Wellness Steering Committee; Derrick L. Latos, M.D., chairman of the WVSMA Council; Alan Holmes, director of the office of Epidemiology and Health Promotion; Lenore Zedosky, RN, BSN, MN, of the West Virginia Department of Education; James M. Stevenson, M.D., of the WVU School of Medicine; Jane Kotchen, M.D., professor of medicine and community health at WVU; William T. Wallace Jr., M.D., commissioner of the Bureau of Public Health; and Taunja Willis Miller, secretary of the WV Department of Health. In addition, presentations were made by the Planned Approach to Community Health (PATCH), Community Oriented Primary Care (COPC), Brooke Bayer Wellness, Health Connections, the West Virginia Wellness Council, and the State Health Education Council (SHEC).

"We have made a commitment to making West Virginia truly a wellness state, taking it from the worst in health status to the first," Dr. Holloway said. "There are several programs underway in the state, but to take full advantage of resources, groups from both the public and private sector will now be unifying efforts."

WV Wellness Coalition

State FP Physicians Plan 39th Scientific Assembly

This year's 39th Annual Scientific Assembly of the West Virginia Chapter of the American Academy of Family Physicians, April 12-14 at Lakeview Resort in Morgantown, will feature updates on depression, prostate cancer, arthritis, Parkinson's disease, ulcers, heart attack, stroke prevention, panic and agoraphobia, dysplastic nevus syndrome, sleep disorders and lipids.

Guest faculty for the conference includes 21 physicians and other health care professionals from 13 states. The program has been reviewed and is acceptable for 19.5 prescribed hours by the American Academy of Family Physicians and by the AMA for 19.5 hours toward the Physicians Recognition Award in Continuing Education. AoA credit towards category 2-A for 19.5 hours is also approved. AoA individual certificate forms will be available at the registration desk, where AAFP computer cards may be also be turned in.

Shahady

Diamond

Mars

Lewis

Brewer

Channick

Prior to the conference on Thursday, April 11, two seminars and the 10th Annual Golf Tournament will be offered for participants. The seminars will be "Practice Management - Billing and Coding," from 10 a.m. - 2 p.m. with Harold Preston of Physician Practice Management in Charleston; and "How an Office Lab with Quality Control Can Help You," from 12:30 p.m. - 2 p.m. featuring Elmer Wahl, M.D., and Judy Wahl of Cincinnati. The golf tournament will kick-off at 1:30 p.m.

The assembly officially begins on Friday, April 12 at 7 a.m. with registration and a continental breakfast followed by opening remarks at 8:15 a.m. by John V. Merrifield, M.D., president-elect of the state AAFP and program chairman. The first scientific session, "Recognition of Depression," by Joseph R. Calabres, M.D., of University Hospitals of Cleveland, will then get underway at 8:25 a.m.

Other scientific presentations on Friday will be: "Differential Diagnosis of Depression," Edward Shahady, M.D., University of North Carolina, Chapel Hill, N.C.; "Treatment of the Depressed Patient," John Zajecka, M.D., Rush-Presbyterian-St. Luke's Medical Center, Chicago; "Advanced Treatment in Prostate Cancer," David Gwin McLeod, M.D., Walter Reed Army Medical Center, Washington, D.C.; "Arthritis Update," Herbert Diamond, M.D., West Penn Hospital, Pittsburgh; "Current Trends in Parkinson's Disease and Treatment," Harold Mars, M.D., Case Western Reserve University, Washington, D.C.; and "Long-Term Management of Ulcer Disease," James H. Lewis, M.D., Georgetown University, Washington, D.C.

On Saturday, April 13, lectures will start at 8 a.m. with Joseph N. DiGiacomo, M.D., of the University of Pennsylvania addressing "The Experience of a Heart Attack in a Small Community Hospital." Also scheduled for Saturday are these topics: "Stroke Prevention, Management and Rehabilitation," George Paulson, M.D.; Ohio State University College of Medicine, Columbus; "Panic and Agoraphobia," Brian Doyle, M.D., Georgetown University Hospital, Washington, D.C.; "Dysplastic Nevus Syndrome," Loren H. Amundson, M.D., University of South Dakota; "Sleep Problems in the Elderly," Thomas Roth, Ph.D., University of Michigan, Detroit; "Critical Update on Coronary Prone Behavior (What Ever Happened to Type A?)," Margaret Chesney, M.D., University of California, San Francisco; and "Diagnostic Evaluation of Syncope in the Elderly," John Brick, M.D., West Virginia University, Morgantown.

The conference will conclude on Sunday, April 14 at noon after a panel discussion is held entitled "The Latest on the Lipids Controversy." Moderator for this panel is Matthew Sokos, M.D., of the Wheeling Family Practice Residency Program in Wheeling, and the panelists will be H. Bryan Brewer, M.D., National Institutes of Health, Bethesda, Md.; Michael H. Davidson, M.D., River City Medical Center, Chicago; Lawrence D. Rink, M.D., Indiana University School of Medicine, Bloomington, Ind.; and Bertram J. Channick, M.D., Temple University Hospital, Philadelphia.

To register or obtain additional information, contact the WVAAFP at 776-1178.

Boston University HealthNET Offers Live Teleconference

Boston University HealthNET, a 7-year-old video education service for medical professionals and health clinics, has begun broadcasting a three-part live teleconference designed to give health care providers new insights into alcohol and drug dependency and AIDS.

The first telecast was aired live via satellite on February 22, and the second and third telecasts will be shown from 10:30 a.m. to 11:30 a.m. EST on March 15 and April 26. The telecasts are interactive, so that medical professionals can join the live discussion on TV by calling a toll-free phone number.

The teleconferences are available nationally to medical institutions with satellite reception dishes, through both Health & Sciences Network and Hospital-NET, and, upon request, to health clinics and individual professionals.

The March 15 telecast will focus on the attitudes of medical professionals toward alcohol and drug addiction, their biases and misconceptions, and how they should diagnose, intervene and interact with patients to assure proper treatment.

The final telecast on April 26 features a session on impaired professionals, including physicians, dentists, nurses, social workers and pharmacists, information on the prevalence of addiction in the health care professions, the contributing factors, and practical advice on how individuals can confront their own problems as well as those of their colleagues.

Dr. Timothy Johnson, medical editor for ABC-TV and WCVB-TV 5 in Boston, will serve as moderator for the second and third telecasts.

All of the telecasts carry continuing education credits for licensing purposes for physicians, nurses, social workers, pharmacists, nutritionists and dentists. Credits are available for $50 per telecast for each viewing site, regardless of the number of participants, or $125 for the package of three telecasts.

Those interested should contact HealthNET at (617) 638-5110 for registration and credit information.

CAMC Awarded Level I Designation

The West Virginia Department of Health and Human Resources (WVDHHR) has certified Charleston Area Medical Center as a Level I trauma center and CAMC is the only southern West Virginia institution to achieve this status.

"The Level I status means the state acknowledges CAMC provides the highest level of trauma care available," Dr. James Kessel, medical director of CAMC Trauma Services said. "The Level I designation is based on an objective evaluation and national standards. It's not as though we designated ourselves to be the highest trauma level in the state. We had to meet standards set forth by the American College of Surgeons. West Virginia is one of 11 states that uses the American College of Surgeons' review and classification system."

According to Dr. Kessel, trauma centers are vitally important to the state because West Virginia has the highest vehicular death rate east of Mississippi and the problem is particularly acute in rural areas. "The only way to have an impact on the death rate is by having a system in place to rapidly identify and transport these victims to a center which can give them complete care," he said.

Computerization of Medical Records Topic of Meeting

The 7th Annual International Conference on Computerization of Medical Records will be held April 4-6 in Orlando.

This conference will focus on physicians' needs for clinical information systems and feature optical disk systems, software, the development of standards, and data input workstations. More than 500 attendees are expected to attend the 160 sessions organized in five simultaneous tracks.

For more information, contact the Jill Raines Medical Records Institute, P.O. Box 289, Newton, MA 02160, (617) 964-3923.

Canada Site of National ACPE Conference

The American College of Physician Executives (ACPE) will hold its 15th Annual National Conference on Medical Management in Toronto, Canada, from May 18-21. The conference is designed for physicians who have an active interest in health care management and leadership roles in any sector of the health care industry.

Focusing on the issue of effectiveness in cost, clinical and managerial areas, the program features an extensive agenda of general sessions, workshops and special events.

The broad spectrum of topics includes such titles as:

* Involving physicians in continuous quality improvement
* Trends in physician executive compensation
* Managing costs in clinical support services
* Influence of capitation on patient access and satisfaction
* Building a process for successful physician performance appraisal
* The key to effective quality assurance and utilization review
* Trends in corporate health benefits

ACPE is recognized by the AMA as the specialty society representing physicians in management and is accredited by the Accredition Council for Continuing Medical Education to sponsor continuing medical education for physicians.

Those interested in attending this national conference should contact ACPE at 1-800-562-8088.

Continuing Education

Listed on this page are some of the upcoming continuing education programs which will be held throughout the state.

The programs this month were compiled by the following individuals: Suzanne Nowell, WVU outreach coordinator of continuing medical education; David Bailey, MU director of continuing medical education; Robin Rector, coordinator of continuing medical education for Charleston Area Medical Center; Arlene S. Feder, M.D., coordinator of Medical Grand Rounds for Ohio Valley Medical Center; and Chinmay Datta, M.D., president of the Harrison County Medical Society.

These programs are tentative and subject to change. Further details about these CME activities may be obtained by calling Nowell at 293-3937; Bailey at 696-7018; Rector at 348-9580; Feder at 234-1835; and Datta at 624-2309. Other national and state meetings are listed in the Medical Meetings Section of the *Journal*.

This schedule is presented as a convenience for physicians. If you would like to have the continuing education programs offered by your institution or association published in the *Journal*, please contact Nancy Hill, managing editor, at 925-0342.

CAMC/WVU Health Sciences Center - Charleston

March 16 - "Arrythmia Interpretation and Management: A Workshop for the Primary Care Practitioner," 8 a.m. - 4 p.m., Auditorium (Fee)

March 25 - "The Current Treatment and Management of the Acute Myocardial Infarction," 12:30 p.m. - 1:30 p.m., WVU Bldg. Room 2044

MU School of Medicine - Huntington

April 8 - Pre-Research Day "New Approaches to Development of New or More Effective Viral Vaccines," Robert M. Chanock, M.D., National Institutes of Health, Bethesda, Md., MU Student Center, Shawkey Room 7 p.m.

April 9 - Fourth Annual Research Day, Holiday Inn-Gateway, 7 a.m. - (registration)

Ohio Valley Medical Center - Wheeling

March 13 - "The Menopause Benefits and Risks of Estrogen - Progestogen," Richard Donald Cambrell, M.D., Medical College of Georgia, Augusta, Ga., 8 a.m.

March 27 - "Multi-Organ Failure," Michael Morris Hansen, M.D., St. Francis Medical Center, University of Pittsburgh, Pittsburgh, 8 a.m.

Harrison County Medical Society - Clarksburg

March 7 - "Issues of Acid-Peptic Diseases in the 1990s," James Lewis, M.D., Georgetown University, Washington, D.C., DeCarde, Inc. 7:15 p.m.

CME Outreach Programs

Key to Sponsors

★ WVU Health Sciences Center, Morgantown

☐ CAMC (•)/WVU Health Sciences Center-Charleston (△)

(Check locally for additional information)

Fairmont ★ Fairmont Clinic, March 20, 1 p.m., "Peripheral Neuropathies, Etiologies, Diagnostics, Workups and Treatments," Loreen Breen, M.D.

Hurricane ☐ Putnam General Hospital, March 27, 8:30 a.m. - TBA

Man ☐ Man Appalachian Regional Hospital, March 19, 7 p.m., "Current Treatment of Colitis," Joe White, M.D.

Martinsburg ★ VA Medical Center, March 7, 3 p.m., "Acute Respiratory Failure," Harakh Dednia, M.D.

New Martinsville ★ Wetzel County Hospital, March 14, 11:30 a.m., "Stabilization of High Risk Neonate," Mark Polak, M.D.

Parkersburg ★ Camden Clark Memorial Hospital, March 13, 7 a.m. - "Update on Breast Cancer," Geoffrey Graeber, M.D.

March 20, 7:30 a.m., "Adrenal Disorders," Theodore Kotchen, M.D.

March 27, 7 a.m., "Thrombolytic Therapy in Acute Myocardial Infarction," Abnash Jain, M.D.

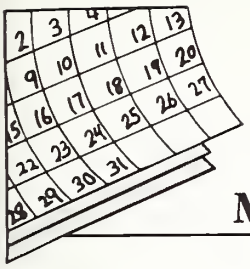
Point Pleasant ☐ Pleasant Valley Hospital, March 28, noon - TBA

Ripley ☐ Jackson General Hospital, March 8, "Neonatal Resusitation," Stefan Maxwell, M.D.

Ronceverte ☐ Humana Hospital Greenbrier Valley, March 20, 1 p.m. - TBA

Spencer ☐ Roane General Hospital, March 19, 12:30 p.m., "Neonatal Resusitation," Stefan Maxwell, M.D.

Waynesburg, Pa. ★ Greene County Memorial Hospital, March 26, 7 p.m., "Management of Obesity," Irma Ullrich, M.D.



Medical Meetings

March

8-9—Second Annual Ophthalmology Alumni Weekend WVU Department of Ophthalmology, Morgantown.
15-16—Lipids, Ohio State University, Columbus.
15-17—Office Management of Infectious Diseases, Southern Medical Association, Destin, FL.
21-23—Introductory Perimetry Course, Ohio State University, Columbus.
21-22—Standards of Care and Recertification, American Boards of Medical Specialties, Chicago.

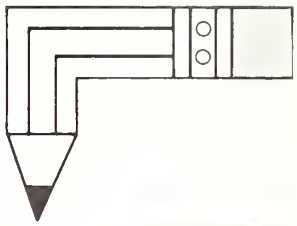
April

5-6—Geriatric Clinical Update: Treatable Cases of Dependency, Ohio State University, Columbus.
10-13—A Comprehensive Review of Clinical Obstetrics and Gynecology, Georgetown University Medical Center, Washington, D.C.
11—How to Manage a More Profitable Practice, Southern Medical Association, Atlanta.
17-21—Critical Care Medicine 91, Society of Critical Care Medicine and Rush - Presbyterian - St. Luke's Medical Centers, Rockville, Md.
19-20—Update Workshop in Diabetes: Pathogenesis and Treatment of Non-insulin-Dependent Diabetes Mellitus, Ohio State University, Columbus.
19-20—Intense MRI Neuro Review, Magnetic Resonance Imaging Education Foundation Inc., Cincinnati.
19-20—Spring Meeting WV Chapter of the American Academy of Pediatrics: Issues for the Practitioner, Wheeling.
19-21—Focus on the Athletic Patient, Southern Medical Association, Hilton Head, S.C.
19-21—Advances in Surgical Techniques and Technologies, Southern Medical Association.
20—Management of Common Bile Stones and Biliary Structures: A Multidisciplinary Approach, Georgetown University Medical Center, Washington, D.C.
21-23—8th National Conference on Prescription Medicine Information: Managing Diversity in Medicine Communication, Washington, D.C.
21-24—Introductory Perimetry Course, Ohio State University, Columbus.
26-28—Diagnostic Dilemmas in Cardiology, Southern Medical Association, Myrtle Beach, S.C.
29-May 1—Carolinas Medical Center Spring Symposium 91, Charlotte, N.C.

For More Information . . .

Contact The Journal for additional information about most of the above meetings. Call (304) 925-0342.

Poetry Corner



Mediterranean Shores

The wet sand, now out of reach
Of the white waves
That seconds before covered it,
Glistens pink in the reflection
Of the setting sun, the fiery chariot
That pulls the blanket of night Westward
And tucks it around Gibralter's Rock.

Soon the Mediterranean night
Is filled with the ghosts of the world's
history:
Portuguese and Spanish explorers of the sea
expanding the boundaries of the known
world,
Muslims and Christians conquering and
being conquered,
The expansion and contraction of the
Roman Empire,
Voyages of Christ's apostles, and
The three-year ministry of God Incarnate,

Phoenicians founding Cadiz and Barcelona,
The mighty Grecian Philosophers,
The Egyptian pyramid-builders,
Moses leading the children of Israel,
Probably even Adam and Eve.

To sit by these blue waters
And reflect that civilization indeed
Sprang from these shores,
Fills one with awesome respect
For the timelessness of this basin.

Robert L. Smith, M.D.

Please address your submissions for Poetry Corner to: Stephen D. Ward, M.D., Editor, West Virginia Medical Journal, Box 4106, Charleston, WV 25364.

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WEST VIRGINIA UNIVERSITY HEALTH SCIENCES CENTER

Compiled from material furnished by the West Virginia University Health Sciences Center News Service, Morgantown.

National Alzheimer's Research Center to Be Created

West Virginia University will be the site of a federally funded Center for Nuclear Medicine Research in Alzheimer's Disease and Related Disorders.

"Once again, the efforts of Senator Robert C. Byrd are bringing world-class research to West Virginia," Dr. Robert D'Alessandri, dean of WVU's School of Medicine said. "This project will be of particular benefit to West Virginia because of the large number of older people residing in the state. We are going to be able to gain new insight into diseases which affect the brain during the aging process."

The center--which is expected to be allocated $10 million from the U.S. Department of Energy--will house a Positron Emission Tomography (PET) scanning device.

"This will allow us to do research that can only be done in a few places in the country," Dr. Deborah Willard, a faculty member in radiology in the School of Medicine said. "We think it has a lot of promise."

"The PET scanner enables a doctor to actually watch the brain function," Dr. D'Alessandri explained. "You can't see what someone is thinking, but you can determine with a great deal of precision which areas of the brain are responding to stimulation. It has the potential to become a very important tool in the study of brain disorders," he added.

The PET scanner is used by injecting the patient with a radioactive tracer. The tracer, often a sugar solution, emits positrons at a predictable rate. The positron is a positively-charged subatomic particle with the same mass and magnitude of electrical charge as an electron.

By mapping the distribution of positrons in a portion of the brain, the scanner produces a picture of the metabolism of the sugar in the brain--allowing researchers and physicians to determine which areas of the brain are active.

Using other tracers, the scanner can map blood flow or other functions in the heart of elsewhere in the body.

Baylis Awarded $40,000 for Kidney Research

Dr. Christine Baylis of WVU's department of physiology, is the recipient of a $40,000 three-year award from the Baxter Healthcare Corporation's Renal Division for her research involving renin/angiotensin and sodium sensitivity in aging.

Dr. Baylis was one of 11 finalists to be awarded a grant in Baxter's extramural grant program and proposals applied to two research categories: dialysis in the elderly and acute renal failure.

"Renin/angiotensin are chemically-linked hormones in the human body which help to control blood pressure and sodium excretion," Dr. Baylis said. "Research in this area shows major potential for treatment in older people. As people get older, there are profound differences in the kidney and there's a marked slowing in the kidney's function, particulary in men."

Dr. Baylis joined WVU nearly four years ago but has conducted research on aging kidneys for six years. An independent medical advisory board of international renal disease experts reviewed 57 proposals and selected the final recipients based on the scientific merit of their proposals and their potential to meet unanswered health needs, according to Baxter Healthcare Corp. which is based in Deerfield, Il. Worldwide, it is estimated that 30 million persons suffer from kidney disease and that over 200,000 undergo dialysis treatments at hospitals or in their homes. Additionally, over 100,000 persons will die from kidney-related diseases by the end of the year.

"These awards serve a dual purpose," Dr. Baylis said. "Not only are these grants crucial in sustaining renal research, they also serve as an incentive to scientists who can see the commitment that industry has made to improving kidney treatment."

Baxter is announcing two upcoming deadlines for research proposal submissions: April 12 (two topics) 1. Beta-Microglobulin Amyloidosis and 2. open category; and Nov. 15 (two topics) 1. preservation of residual renal function and 2. the dialysis patient and nutrition.

For further information concerning applications, contact Mary Hoffman, Baxter Healthcare (708) 270-5203.

Beattie Named to National Test Committee

Diana S. Beattie, Ph.D., chair of the department of biochemistry in the WVU School of Medicine, has been appointed to the Part 1 Biochemistry Test Committee by the National Board of Medical Examiners.

The committee designs, develops and ensures the integrity of the tests used to measure the knowledge and competency of medical students and physicians. National Board tests are a part of the licensing procedure in nearly every state.

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Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

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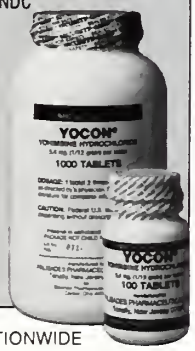
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85



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MU School Of Medicine News

Compiled from material furnished by the Office of University Relations, Marshall University

MU Endocrinologist Studying in Australia

A Marshall doctor's search for an understanding of the relationship between vitamin A, insulin, and diabetes has carried him to an internationally-renowned research institute in Australia.

Dr. Bruce Chertow, chief of endocrinology at the MU School of Medicine, is engaged in a five-year study funded by the U.S. Department of Veterans Affairs to determine how vitamin A deficiency may lead to abnormally low release of insulin or to problems in the growth of cells that release insulin. He left in January for a six-month sabbatical at Baker Institute in Melbourne, Australia to gain state-of-the-art training in molecular biology.

"We were the first laboratory to show that vitamin A is required for insulin secretion," Dr. Chertow said. "The next questions to answer are how does it affect insulin secretion and what is the mechanism at the molecular level? Baker Institute is widely recognized for its researchers' expertise in the biologic tools needed to study this aspect of molecular function and my training under Dr. John W. Funder at Baker will benefit my research in West Virginia.

"It is known that a super family of protein receptors serves as keys to unlock the door of the nucleus to vitamin A and certain hormones. Once this door is unlocked, different sets of genes can be expressed to produce the products, such as insulin, that are needed to regulate various cell functions. At Baker Institute I want to discover if these proteins are in the pancreatic islets that secrete insulin."

Dr. Chertow's study has particular significance for West Virginians because rural citizens have both a high rate of diabetes and vitamin A deficiency. In addition, Dr. Chertow's work at Baker Institute will focus on how insulin might contribute to hypertension and heart disease, two other diseases common in West Virginia.

New Estrogen Product Being Tested

Doctors at the MU School of Medicine are helping to test a new product that may provide a safe, more effective way of administering estrogen to menopausal women.

The 11-week study compares two ways of replacing the body's diminishing supply of estrogen — by taking oral capsules and by applying a patch to the skin, according to Sandy White, coordinator of clinical studies for the Department of Obstetrics and Gynecology. The newer transdermal system, as the patch is called, allows small quantities of the hormone estradiol to flow through the skin directly into the bloodstream.

The patch, which is placed on the trunk of the body, is changed only once a week, White explained. Oral capsules, on the other hand, must be taken every day. Patients are followed closely through office visits and weekly phone calls. They also benefit from free physical, pelvic and breast exams, pap smears, EKGs, and blood work, White said.

It is well documented that estrogen replacement alleviates hot flashes and prevents the bone demineralization characteristic of osteoporosis, White said. Research now underway suggests that estrogen may also guard against heart disease and death from strokes.

About 25 medical centers across the country are involved in the double-blinded study in which neither the patients nor the investigators know which system is delivering active drug to the patient. Dr. Sherwood C. Lynn Jr., associate professor in the Department of Obstetrics and Gynecology, is the chief investigator for the study.

MU Ranked Nationally for FP Residencies

The MU School of Medicine ranked No. 2 in the nation last year in the percentage of its graduates entering family practice residencies, Dean Charles H. McKown Jr. has announced.

"This is additional proof, if more was needed, that Marshall's directed focus on the 'front-line' medical specialities does indeed produce primary-care physicians at a rate far above the national average," Dr. McKown said.

For the 1989-90 academic year, nearly 32 percent of Marshall's graduates entered family practice residencies, more than 2.5 times the national average of 12.1 percent, according to figures from the American Academy of Family Physicians.

Over the last decade, Marshall's percentage of graduates entering family practice residencies has been 21.1 percent, nearly twice the national average of 11.8 percent, academy figures show. Nationally, Marshall ranks 14th out of the 126 schools studied.

Dr. McKown noted that approximately two-thirds of Marshall's graduates overall enter primary-care fields such as internal medicine, pediatrics and obstetrics/gynecology.

"We work hard to produce these results," Dr. McKown said. "We're careful in the applicants we accept, we tailor the curriculum for all four years to emphasize primary care, and we make sure students have ample opportunities to become involved in rural care and interact with doctors who enjoy that kind of practice."

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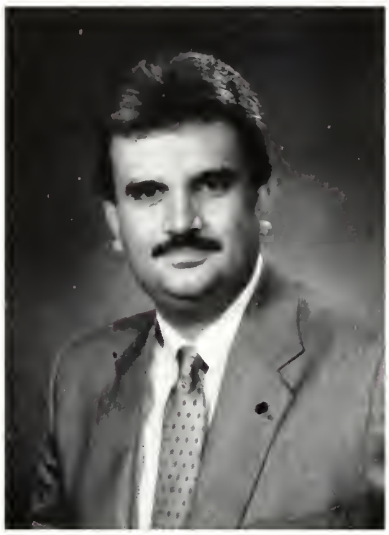

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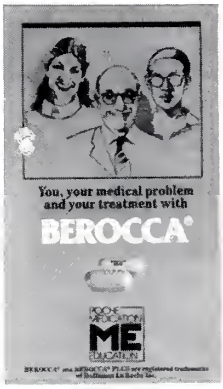

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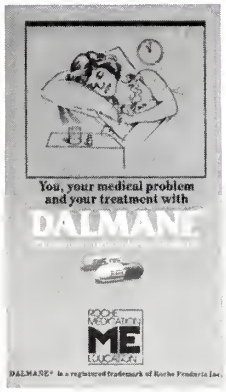

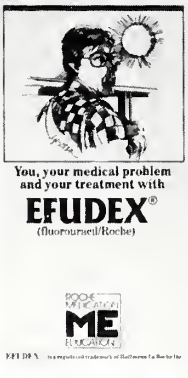

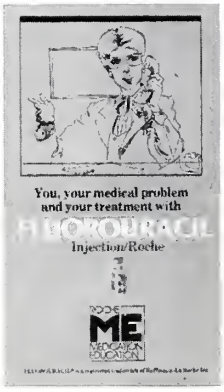

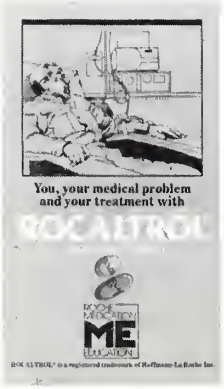

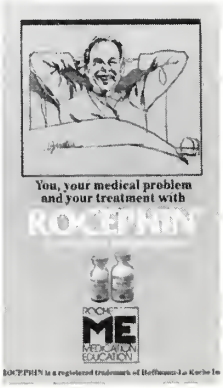

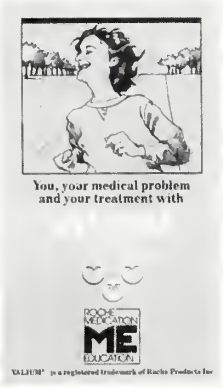

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Hypotension: Excessive hypotension is rare in uncomplicated hypertensive patients treated with VASOTEC alone. Patients with heart failure given VASOTEC commonly have some reduction in blood pressure, especially with the first dose, but discontinuation of therapy for continuing symptomatic hypotension usually is not necessary when dosing instructions are followed; caution should be observed when initiating therapy. (See DOSAGE AND ADMINISTRATION.) Patients at risk for excessive hypotension, sometimes associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death, include those with the following conditions or characteristics: heart failure, hyponatremia, high-dose diuretic therapy, recent intensive diuresis or increase in diuretic dose, renal dialysis, or severe volume and/or salt depletion of any etiology. It may be advisable to eliminate the diuretic (except in patients with heart failure), reduce the diuretic dose, or increase salt intake cautiously before initiating therapy with VASOTEC in patients at risk for excessive hypotension who are able to tolerate such adjustments. (See PRECAUTIONS, *Drug Interactions* and ADVERSE REACTIONS.) In patients at risk for excessive hypotension, therapy should be started under very close medical supervision and such patients should be followed closely for the first two weeks of treatment and whenever the dose of enalapril and/or diuretic is increased. Similar considerations may apply to patients with ischemic heart disease or cardiovascular disease in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident.

If excessive hypotension occurs, the patient should be placed in the supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses of VASOTEC, which usually can be given without difficulty once the blood pressure has stabilized. If symptomatic hypotension develops, a dose reduction or discontinuation of VASOTEC or concomitant diuretic may be necessary.

Neutropenia/Agranulocytosis: Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease. Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis at similar rates. Foreign marketing experience has revealed several cases of neutropenia or agranulocytosis in which a causal relationship to enalapril cannot be excluded. Periodic monitoring of white blood cell counts in patients with collagen vascular disease and renal disease should be considered.

Fetal/Neonatal Morbidity and Mortality: ACE inhibitors, including VASOTEC, can cause fetal and neonatal morbidity and mortality when administered to pregnant women.

Enalapril crosses the human placenta. When ACE inhibitors have been used during the second and third trimesters of pregnancy, there have been reports of hypotension, renal failure, skull hypoplasia, and/or death in the newborn. Oligohydramnios has also been reported, presumably representing decreased renal function in the fetus, limb contractures, craniofacial deformities, hypoplastic lung development and intrauterine growth retardation have been reported in association with oligohydramnios. Patients who do require ACE inhibitors during the second and third trimesters of pregnancy should be apprised of the potential hazards to the fetus, and frequent ultrasound examinations should be performed to look for oligohydramnios. If oligohydramnios is observed, VASOTEC should be discontinued unless it is considered life-saving for the mother.

Other potential risks to the fetus/neonate exposed to ACE inhibitors include: intrauterine growth retardation, prematurity, patent ductus arteriosus; fetal death has also been reported. It is not clear, however, whether these reported events are related to ACE inhibition or the underlying maternal disease. It is not known whether exposure limited to the first trimester can adversely affect fetal outcome.

Infants exposed *in utero* to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion.

Enalapril has been removed from the neonatal circulation by peritoneal dialysis and theoretically may be removed by exchange transfusion, although there is no experience with the latter procedure.

There was no fetotoxicity or teratogenicity in rats treated with up to 200 mg/kg/day of enalapril (333 times the maximum human dose). Fetotoxicity, expressed as a decrease in average fetal weight, occurred in rats given 1200 mg/kg/day of enalapril, but did not occur when these animals were supplemented with saline. Enalapril was not teratogenic in rabbits. However, maternal and fetal toxicity occurred in some rabbits at doses of 1 mg/kg/day or more. Saline supplementation prevented the maternal and fetal toxicity seen at doses of 3 and 10 mg/kg/day but not at 30 mg/kg/day (50 times the maximum human dose).

If VASOTEC is used during pregnancy or if the patient becomes pregnant while taking VASOTEC, the patient should be apprised of the potential hazards to the fetus.

Precautions: *General. Impaired Renal Function:* As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including VASOTEC, may be associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20% of patients. These increases were almost always reversible upon discontinuation of enalapril and/or diuretic therapy. In such patients, renal function should be monitored during the first few weeks of therapy.

Some patients with hypertension or heart failure with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when VASOTEC has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Dosage reduction and/or discontinuation of the diuretic and/or VASOTEC may be required.

Evaluation of patients with hypertension or heart failure should always include assessment of renal function. (See DOSAGE AND ADMINISTRATION.)

Hyperkalemia: Elevated serum potassium (> 5.7 mEq/L) was observed in approximately 1% of hypertensive patients in clinical trials. In most cases these were isolated values which resolved despite continued therapy. Hyperkalemia was a cause of discontinuation of therapy in 0.28% of hypertensive patients. In clinical trials in heart failure, hyperkalemia was observed in 3.8% of patients, but was not a cause for discontinuation.

Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with VASOTEC. (See *Drug Interactions*.)

Cough: Cough has been reported with the use of ACE inhibitors. Characteristically, the cough is nonproductive, persistent and resolves after discontinuation of therapy. ACE inhibitor-induced cough should be considered as part of the differential diagnosis of cough.

Surgery/Anesthesia: In patients undergoing major surgery or during anesthesia with agents that produce hypotension, enalapril may block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

Information for Patients: Angioedema: Angioedema, including laryngeal edema, may occur especially following the first dose of enalapril. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to take no more drug until they have consulted with the prescribing physician.

Hypotension: Patients should be cautioned to report lightheadedness, especially during the first few days of therapy. If actual syncope occurs, the patients should be told to discontinue the drug until they have consulted with the prescribing physician.

All patients should be cautioned that excessive perspiration and dehydration may lead to an excessive fall in blood pressure because of reduction in fluid volume. Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure; patients should be advised to consult with the physician.

Hyperkalemia: Patients should be told not to use salt substitutes containing potassium without consulting their physician.

Neutropenia: Patients should be told to report promptly any indication of infection (e.g., sore throat, fever) which may be a sign of neutropenia.

NOTE: As with many other drugs, certain advice to patients being treated with enalapril is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

Drug Interactions: Hypotension: Patients on Diuretic Therapy: Patients on diuretics and especially those in whom diuretic therapy was recently instituted may occasionally experience an excessive reduction of blood pressure after initiation of therapy with enalapril. The possibility of hypotensive effects with enalapril can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with enalapril. If it is necessary to continue the diuretic, provide close medical supervision after the initial dose for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and DOSAGE AND ADMINISTRATION.)

Agents Causing Renin Release: The antihypertensive effect of VASOTEC® (Enalapril Maleate, MSD) is augmented by antihypertensive agents that cause renin release (e.g., diuretics).

Other Cardiovascular Agents: VASOTEC has been used concomitantly with beta-adrenergic-blocking agents, methyldopa, nitrates, calcium-blocking agents, hydralazine, prazosin, and digoxin without evidence of clinically significant adverse interactions.

Agents Increasing Serum Potassium: VASOTEC attenuates potassium loss caused by thiazide-type diuretics. Potassium-sparing diuretics (e.g., spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium. Therefore, if concomitant use of these agents is indicated because of demonstrated hypokalemia, they should be used with caution and with frequent monitoring of serum potassium. Potassium-sparing agents should generally not be used in patients with heart failure receiving VASOTEC.

Lithium: Lithium toxicity has been reported in patients receiving lithium concomitantly with drugs which cause elimination of sodium, including ACE inhibitors. A few cases of lithium toxicity have been reported in patients receiving concomitant VASOTEC and lithium and were reversible upon discontinuation of both drugs. It is recommended that serum lithium levels be monitored frequently if enalapril is administered concomitantly with lithium.

Pregnancy: Pregnancy Category D. See WARNINGS, *Fetal/Neonatal Morbidity and Mortality*.

Nursing Mothers: Enalapril and enalaprilat are detected in human milk in trace amounts. Caution should be exercised when VASOTEC is given to a nursing mother.

Pediatric Use: Safety and effectiveness in children have not been established.

Adverse Reactions: VASOTEC has been evaluated for safety in more than 10,000 patients, including over 1000 patients treated for one year or more. VASOTEC has been found to be generally well tolerated in controlled clinical trials involving 2987 patients.

HYPERTENSION: The most frequent clinical adverse experiences in controlled trials were: headache (5.2%), dizziness (4.3%), and fatigue (3%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in controlled clinical trials were: diarrhea (1.4%), nausea (1.4%), rash (1.4%), cough (1.3%), orthostatic effects (1.2%), and asthenia (1.1%).

HEART FAILURE: The most frequent clinical adverse experiences in both controlled and uncontrolled trials were: dizziness (7.9%), hypotension (6.7%), orthostatic effects (2.2%), syncope (2.2%), cough (2.2%), chest pain (2.1%), and diarrhea (2.1%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in both controlled and uncontrolled clinical trials were: fatigue (1.8%), headache (1.8%), abdominal pain (1.6%), asthenia (1.6%), orthostatic hypotension (1.6%), vertigo (1.6%), angina pectoris (1.5%), nausea (1.3%), vomiting (1.3%), bronchitis (1.3%), dyspnea (1.3%), urinary tract infection (1.3%), rash (1.3%), and myocardial infarction (1.2%).

Other serious clinical adverse experiences occurring since the drug was marketed or adverse experiences occurring in 0.5% to 1% of patients with hypertension or heart failure in clinical trials in order of decreasing severity within each category.

Cardiovascular: Cardiac arrest, myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high-risk patients (see WARNINGS, *Hypotension*), pulmonary embolism and infarction, pulmonary edema, rhythm disturbances including atrial tachycardia and bradycardia; atrial fibrillation; palpitation.

Digestive: Ileus, pancreatitis, hepatitis [hepatocellular [proven on rechallenge] or cholestatic jaundice], melena, anorexia, dyspepsia, constipation, glossitis, stomatitis, dry mouth.

Musculoskeletal: Muscle cramps.

Nervous/Psychiatric: Depression, confusion, ataxia, somnolence, insomnia, nervousness, paresthesia.

Respiratory: Bronchospasm, rhinorrhea, sore throat and hoarseness, asthma, upper respiratory infection.

Skin: Exfoliative dermatitis, toxic epidermal necrolysis, Stevens-Johnson syndrome, herpes zoster, erythema multiforme, urticaria, pruritus, alopecia, flushing, diaphoresis.

Special Senses: Blurred vision, taste alteration, anosmia, tinnitus, conjunctivitis, dry eyes, tearing.

Urogenital: Renal failure, oliguria, renal dysfunction (see PRECAUTIONS and DOSAGE AND ADMINISTRATION), impotence.

A symptom complex has been reported which may include a positive ANA, an elevated erythrocyte sedimentation rate, arthralgia/arthritis, myalgia, fever, serositis, vasculitis, leukocytosis, eosinophilia, photosensitivity, rash, and other dermatologic manifestations.

Angioedema: Angioedema has been reported in patients receiving VASOTEC (0.2%). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with VASOTEC should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

Hypotension: In the hypertensive patients, hypotension occurred in 0.9% and syncope occurred in 0.5% of patients following the initial dose or during extended therapy. Hypotension or syncope was a cause for discontinuation of therapy in 0.1% of hypertensive patients. In heart failure patients, hypotension occurred in 6.7% and syncope occurred in 2.2% of patients. Hypotension or syncope was a cause for discontinuation of therapy in 1.9% of patients with heart failure. (See WARNINGS.)

Fetal/Neonatal Morbidity and Mortality: In infants exposed *in utero* to ACE inhibitors the following adverse experiences have been reported: Fetal and neonatal death, renal failure, hypoplastic lung development, hypotension, hyperkalemia, skull hypoplasia, limb contractures, craniofacial deformities, intrauterine growth retardation, prematurity and patent ductus arteriosus. (See WARNINGS, *Fetal/Neonatal Morbidity and Mortality*.)

Clinical Laboratory Test Findings: Serum Electrolytes: Hyperkalemia (see PRECAUTIONS), hyponatremia.

Creatinine, Blood Urea Nitrogen: In controlled clinical trials, minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinuation of therapy, were observed in about 0.2% of patients with essential hypertension treated with VASOTEC alone. Increases are more likely to occur in patients receiving concomitant diuretics or in patients with renal artery stenosis. (See PRECAUTIONS.) In patients with heart failure who were also receiving diuretics with or without digitalis, increases in blood urea nitrogen or serum creatinine, usually reversible upon discontinuation of VASOTEC and/or other concomitant diuretic therapy, were observed in about 11% of patients. Increases in blood urea nitrogen or creatinine were a cause for discontinuation in 1.2% of patients.

Hemoglobin and Hematocrit: Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0.3 g% and 1.0 vol%, respectively) occur frequently in either hypertension or heart failure patients treated with VASOTEC but are rarely of clinical importance unless another cause of anemia coexists. In clinical trials, less than 0.1% of patients discontinued therapy due to anemia.

Other (Causal Relationship Unknown): In marketing experience, rare cases of neutropenia, thrombocytopenia, and bone marrow depression have been reported. A few cases of hemolysis have been reported in patients with G6PD deficiency.

Liver Function Tests: Elevations of liver enzymes and/or serum bilirubin have occurred.

For more detailed information, consult your MSD Representative or see Prescribing Information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, PA 19486. J9VS61R2(824)

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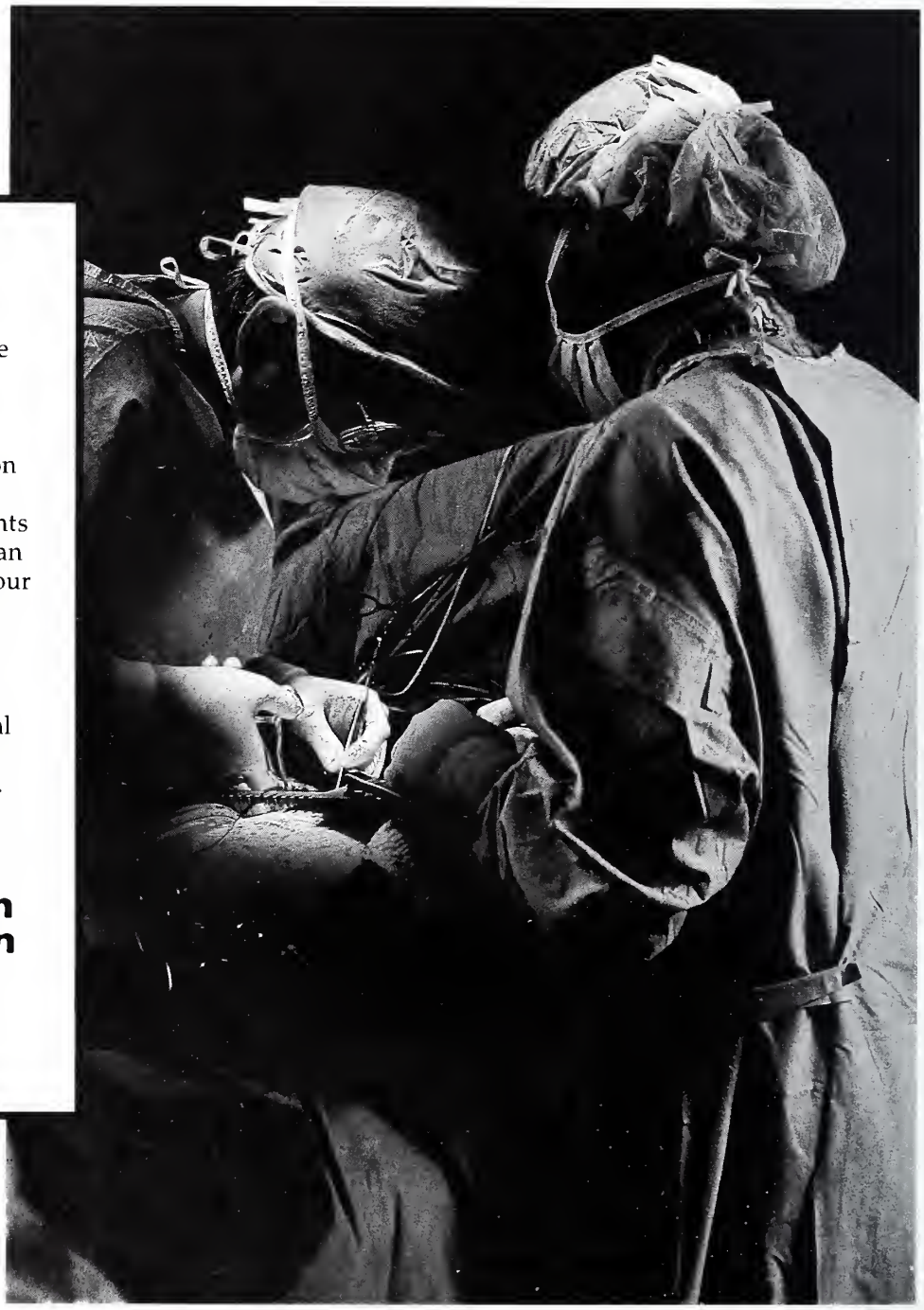
Front Cover

Sunset at Centennial Roadside Park overlooking Backbone Mountain in Tucker County is a breathtaking sight. Photo courtesy *Stephen J. Shaluta Jr., West Virginia Department of Commerce.*

Sometimes Being Sure Of Yourself Just Isn't Enough.



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Medical Malpractice Cases and Awards: 1980-1990

Editor's Note: *The following is a report compiled by Perry Productions of Charleston from information provided by the West Virginia Board of Medicine. The West Virginia Medical Association sponsored the manpower to collect this data on malpractice cases and judgments from the Board of Medicine because the Board did not have the capability to process it. These figures show that over $123 million in awards has been paid out from 1980-1990. This total must be considered in its context for it will not be a final figure, as more cases will be settled for that time frame. Total cases to date in the 10-year period were 1,899, of which 1,290 were settled, 138 were judged and 462 were dismissed or no award given. To date, 13 cases have resulted in over $1 million in awards.*

Year	Total Cases	Total Settled	Total Amount of of Cases Settled	Total Judged	Total Amount of of Cases Judged	Total Dismissed or No Award	Cases Over $1 Million	Total Amount of Cases Over $1 Million
1980	14	14	$ 216,000.00	0	0	0	0	0
1981	24	23	$ 1,418,004.00	1	$ 12,500.00	1	0	0
1982	31	26	$ 1,421,465.85	2	$2,985,000.00	3	1	$2,000,000.00
1983	60	50	$ 2,675,828.25	2	$ 176,000.00	8	0	0
1984	110	84	$ 5,219,970.52	6	$ 602,500.00	20	0	0
1985	156	112	$ 8,163,019.07	9	$ 284,641.71	35	1	$1,500,000.00
1986	189	135	$ 7,080,631.15	20	$6,828,039.78	34	2	$1,100,000.00 $1,500,000.00
1987	291	224	$23,990,033.62	16	$ 348,663.38	47	2	$2,000,000.00 $2,000,000.00
1988	378	258	$26,315,263.02	25	$7,563,958.23	93	1	$5,000,000.00
1989	388	218	$23,778,854.74	34	$1,571,928.06	132	2	$2,000,000.00 $2,250,000.00
1990	258	146	$23,166,235.38	23	$ 966,192.48	89	4	$1,849,137.00 $1,000,000.00 $1,180,095.00* $2,200,761.00** * (structured settlement) Only $80,190 was paid in 1990. No information on how balance of $1,099,905 is to be paid. ** (structured settlement, total of payments made in 1990)
TOTAL								
1980 1990	1,899	1,290	$123,445,305.60	138	$21,339,423.64	462	13	$25,579,993.00

Seminoma: A Review of 15 Years Experience

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Abstract

We retrospectively reviewed the Charleston Area Medical Center (CAMC) experience with 54 patients diagnosed with seminoma between 1970 and 1986. The median age at diagnosis was 37.5 years (range 20-79). The highest percentage of seminomas occurred between the ages of 30 and 39 (50 percent). Treatment was primarily orchiectomy and radiotherapy since most patients presented with localized disease. The five year survival rate was 100 percent for stage I, 86 percent for stage II, and 75 percent for stage III. Sixteen of 18 (89 percent) stage I patients survived at least 10 years. Of the 12 patients who died, two (16 percent) died of recurrent seminoma, six of cardiovascular disease, and four of a second primary malignancy. The excellent five and 10-year survival rates in stage I seminoma treated with surgery and radiotherapy in this series is similar to others.

Introduction

Germ-cell tumors of the testis account for only 1 percent-2 percent of all tumors in males, yet they are the most common solid tumor in males ages 20-39 (1). Seminomas comprise 30 percent of all germ-cell tumors and 72 percent of germ cell tumors of one histologic type (2). Since testicular tumors are not very common, it has been difficult to obtain sufficient clinical and pathologic experience in one institution.

The purpose of this study is to review the Charleston Area Medical Center (CAMC) experience with 54 patients with seminoma treated over a period of 15 years from 1970 to 1986. Where indicated, comparisons are made between the findings in this study and those of the American College of Surgeons' (ACOS) National Survey of Patterns of Care for Testis Cancer (3).

Methods

CAMC tumor registry records were used to identify 54 patients with histologically proven seminomatous germ-cell tumors of the testis diagnosed and/or given first-course therapy between 1970 and 1986. A data base was then constructed using inpatient medical records and outpatient radiotherapy and chemotherapy charts. Information collected on each patient included pathologic diagnosis, age at diagnosis, past/family history, signs and symptoms, staging radiographic and laboratory studies including serum levels of beta subunit of human chorionic gonadotropin (B-HCG) and alpha-fetoprotein, stage at diagnosis, treatment given, follow-up/recurrences, and survival time. Staging was done according to the system employed by the NIH Testicular Cancer Intergroup Study (4). Survival time in months was calculated from the date of diagnosis.

Results

Of 86 patients with germ-cell tumors of the testis, 54 (63 percent) were reported as pure seminomas. Forty-nine of these were typical seminoma, 2 were anaplastic seminoma, 2 were spermatocytic seminoma, and 1 seminoma had all three cell types. The median age at diagnosis was 37.5 years (range 20-79). The highest percentage of seminomas occurred between the ages of 30 and 39 (50 percent).

The most common presenting symptoms were testicular swelling in 26 patients (48 percent), testicular mass in 11 (20 percent), testicular pain in nine (17 percent), and lower quadrant and/or flank pain in three (5.5 percent). An incidental finding of a palpable mass by the patient's physician was noted in five cases (9 percent). The duration of symptoms was less than three months in 26 (48 percent) patients, three to six months in 16 (30 percent), and greater than six months in seven (13 percent). There was no elevation of B-HCG or AFP in the 35 and 28 patients, respectively, in whom it was measured. Thirty-nine (72 percent) patients were stage I, 10 (18.5 percent) stage II, and five (9 percent) stage III at presentation.

An orchiectomy was performed in all 54 patients, 50 inguinal and four scrotal. Only one patient (1.9 percent) had a retroperitoneal lymph node dissection after orchiectomy. Thirty-seven of 39 (95 percent) stage I seminoma patients received radiation (2,500-4,000 rads) to the para-aortic and ipsilateral inguinal and iliac lymph nodes ("hockeystick field") only. Two (5 percent) of these received additional radiation to the mediastinal and supraclavicular nodes. All 10 stage II patients received radiation therapy (2,600-4,120 rads) to the "hockeystick field," six of whom also received mediastinal and supraclavicular radiation therapy (2,004-3,150 rads). Three of five (60 percent) stage III patients were treated with radiation (2,970-3,500 rads) to both the "hockeystick" and mediastinal/supraclavicular areas. One patient developed hepatic metastases and received chemotherapy, and another died of metastatic disease before treatment began.

During the study period there were 12 deaths, only two of which were due to recurrent or metastatic disease. Four were due to a second primary cancer (nasopharynx, lung,

TABLE I. Seminoma: A Comparison of CAMC Cases with ACOS National Survey of Patterns of Care for Testis Cancer (3)

	*American College of Surgeons (ACOS)	Charleston Area Medical Center (CAMC)
Total Cases	**2,631**	**54**
% of All Germ Cell Tumors	51%	63%
Median Age (Yrs.) Range	38	37.5 20-79
Symptoms:		
Testicular Swelling	59%	41%
Testicular Pain	32%	17%
Testicular Mass	26%	20%
Abdominal Pain	6%	5.5%
Palpable mass found by physician	3%	9%
Modes of Diagnosis:	(1983)	(1970-1985)
Chest x-ray	90%	81%
Serum AFP	82%	52%
Abdominal CT scan (since 1981)	76%	50%
Serum B-HCG	73%	65%
Intravenous pyelogram	39%	54%
Lymphangiogram	24%	41%
Bone nuclide scan	12%	17%
Clinical/Pathological Stage at Presentation:		
I	77%	72%
II	19%	19%
III	4%	9%

*Seminoma cases only were included in this tabulation although both seminoma and non-seminoma germ-cell tumors were studied.

colon, and rectum), and six to cardiovascular disease (1 myocardial infarction, 1 congestive heart failure, 2 cardiorespiratory arrests, 1 atherosclerotic heart disease, and 1 thrombophlebitis).

The five-year survival was 100 percent for stage I, 86 percent for stage II, and 75 percent for stage III patients. A crude 10-year survival was calculated for the 26 patients diagnosed on or before 1980. Sixteen of 18 (89 percent) stage I patients survived 10 years. Of the two that did not survive, one was lost to follow-up and the other died of a cardiopulmonary arrest. None of the four stage II patients diagnosed before 1980 survived 10 years. One was lost to follow-up, two died of second malignancies at 28 and 108 months, and one died of recurrent testicular cancer at 18 months. Of the four stage III patients, two (50 percent) are alive at 147 and 184 months. One died of atherosclerotic heart disease at 7 months and one of metastatic testicular cancer at 3 months.

Discussion

The American College of Surgeons' (ACOS) Survey of Patterns of Care for Testis Cancer from 1970-1975 reviewed 3,285 patients from 397 hospitals for a long-term study and reviewed 1,887 patients diagnosed in 1983 from 519 hospitals for a short-term study (3). The data on age and incidence were consistent with that found in Surveillance, Epidemiology, and End Results (SEER) (5). Therefore, the ACOS study provides an excellent background with which the CAMC seminoma patients can be compared. (See Tables I and II.)

Our study found a slightly higher percentage of all germ-cell tumors to be seminomas (63 percent vs. 51 percent). The median ages at diagnosis in the two studies were almost identical (37.5 vs. 38). The most common initial symptom was testicular swelling in both studies. Other symptoms were similar in both studies except that our study noted fewer patients with testicular pain (17 percent vs. 32 percent) and more patients whose testicular mass was discovered incidentally (9 percent vs. 3 percent).

The modes of diagnosis used in the two studies were similar except that CAT scans and serum biologic markers were used in a lower percentage and intravenous pyelogram (IVP) and lymphangiogram were used in a higher percentage of patients in our study.

The majority of patients in both studies presented with stage I disease (72 percent vs. 77 percent). Nineteen percent of patients in both studies had stage II disease. A slightly higher percentage of patients in our study had stage III disease (9 percent vs. 4 percent).

Treatment in both studies was primarily orchiectomy and radiotherapy since most patients presented with localized disease. In this study, 52 of 54 (96 percent) patients were treated with orchiectomy and radiotherapy. In the ACOS study, 1,292 patients (88 percent) were treated in a similar manner. In that study, a shift in the treatment of stage III patients from orchiectomy and radiotherapy (1970-1975) to orchiectomy and chemotherapy in 1983 was noted. In our study, only one patient with stage III disease received chemotherapy.

The five and 10-year survival rates in both studies demonstrate the excellent survival of patients with early (i.e. stage I) disease. Our five-year survival for stage I disease is 100 percent and of the 18 stage I patients diagnosed on or before 1980, 16 have survived at least 10 years. The 10-year survival rate for stage I patients was 96 percent in the ACOS study. Our study had too few stage II and stage III patients for an adequate comparison of 10-year survival with that of the ACOS study.

Few studies have addressed the causes of death in patients who have received curative therapy for seminoma. Of the 12 patients who

TABLE II. Treatment for Testicular Cancer by Stage: A Comparison of CAMC Cases with ACOS National Survey of Patterns of Care for Testis Cancer (3)

Treatment	Clinical Stage I # (%)	II # (%)	III # (%)
CAMC (1970-1985)			
Surg only	0	0	1
RT or CXT	0	0	0
Surg + RT	39 (100)	10 (100)	3 (80)
Surg + CXT	0	0	1 (20)
Surg + RT + CXT	0	0	0
None	0	0	0
ACOS (1970-1975)			
Surg Only	51 (7.6)	3 (1.8)	3 (6.7)
RT or CXT	2 (0.3)	1 (0.6)	2 (4.4)
Surg + RT	613 (90.8)	154 (93.3)	28 (62.2)
Surg + CXT	3 (0.4)	0	0
Surg + RT + CXT	5 (0.7)	6 (3.6)	10 (22.2)
None	1 (0.1)	1 (0.6)	2 (4.4)
ACOS (1983)			
Surg only	35 (7.8)	3 (2.7)	0
RT or CXT	3 (0.7)	2 (1.8)	2 (10.5)
Surg + RT	406 (90.4)	88 (78.6)	3 (15.8)
Surg + CXT	3 (0.7)	9 (8.0)	11 (57.7)
Surg + RT + CXT	2 (0.4)	10 (8.9)	3 (15.8)
None	0	0	0

Surg: Orchiectomy or Orchiectomy + Retroperitoneal Lymphadenectomy; RT: Radiation Therapy; CXT: Chemotherapy

died in our series, only two (16 percent) died of metastatic or recurrent testicular cancer. One patient with stage II disease underwent scrotal orchiectomy and spermatic cord excision in 1973 and subsequently received 36 radiation treatments. He developed a recurrent pelvic mass in 1974 and received methotrexate and chlorambucil, but died 18 months after diagnosis. The second patient was diagnosed in 1974 with a large retroperitoneal seminoma that displaced the transverse colon, stomach, and kidney. He received 4,650 rads to the "hockeystick" field, but died three months after diagnosis. Six patients (50 percent) died of cardiovascular disease, including myocardial infarction (1), atherosclerotic heart disease (1), cardiopulmonary arrest (2), congestive heart failure (1), and pulmonary embolus (1). Four patients (33 percent) died from a second primary malignancy. One patient died of nasopharyngeal carcinoma at age 82, four years after treatment for his seminoma. A second died at age 61 of metastatic lung cancer six years after completion of treatment. A third died at age 67 of adenocarcinoma of the cecum with abdominal carcinomatosis and hepatic metastases two years after completion of treatment. A fourth died at age 60 of metastatic rectal carcinoma nine years after treatment.

Frelick et al (6) reported seven deaths in 69 patients with seminoma diagnosed between 1972 and 1986. Only one in that study died of metastatic seminoma. Three died of a second primary malignancy, two of a myocardial infarction, and one of pneumonia.

In a study of their experience with seminoma diagnosed between 1960 and 1981, Willan et al (7) reported 12 deaths in 149 stage I patients. Three of these died of recurrent seminoma, four of a second primary malignancy, two of a myocardial infarction, one of congestive heart failure, one of an accidental gunshot, and one of "old age." Of 34 stage II patients, 10 died of seminoma, one of myocardial infarction, and one of "old age." All five stage III patients in that study died from their seminoma.

Our study and others, therefore suggest that deaths due to recurrent seminoma in patients diagnosed with early stage disease (i.e. stage I) are rare. However, patients diagnosed with bulky stage II and III disease are more likely to die of recurrent seminoma.

Etiologic factors for testicular cancer have not been firmly established, although many associations have been observed. Caucasian males have a higher incidence than black Americans, Africans, or Asians (3). All patients in our series were Caucasian. The significance of laterality is unknown.

The right testis is more often (1) involved than the left in most large series. In our series, the right testis was involved in 57 percent and the left in 43 percent. Although cryptorchidism has been associated with 8 percent - 10 percent of cases of testicular cancer (1), no patient in our series gave a history of an undescended testis. A history of mumps or other orchitis is often reported (1). Three patients (5.5 percent) in our series gave a history of mumps and one a history of epididymo-orchitis.

Testicular cancer is often associated with a history of trauma (1) but it is unclear whether the injury calls attention to an already existing tumor or whether the patient's recall is influenced by the knowledge of the cancer. Swerdlow et al (8) recently found no significant association between trauma and testicular cancer. In our study, only three (5.5 percent) reported testicular trauma.

No occupational or geographic association was noted in any of our patients. Of interest is the fact that nine patients (17 percent) gave a history of inguinal hernia, three at the time of diagnosis. Further studies are indicated to confirm this association.

In conclusion, the excellent five and 10-year survival rates in early stage disease (i.e. stage I) treated with orchiectomy and pelvic ± mediastinal radiotherapy in this series is similar to others (3,7,9,10). For patients who present with bulky stage II or stage III disease, improvement in survival may be better achieved with aggressive chemotherapy. However, potential cure for testicular cancer may be most readily obtained through early detection and this can be achieved with better education of the most affected population (males in their 20s and 30s) about the signs and symptoms of this disease.

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Laprascopic Pelvic Lymph Node Dissection

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Abstract

Traditionally, cancer of the prostate has been staged by digital exam, ultrasound, CT scan, bone scan, prostatic acid phosphatase (PAP), and prostate specific antigen (PSA) determinations. These methods commonly lead to understaging, resulting in surgical or radiation therapy of questionable benefit. Pathologic staging, even though reliable and accurate, requires laparotomy with its associated morbidity and lengthy hospitalization/recovery period.

Following national trends, we have recently introduced the technique of Laproscopic Pelvic Lymph Node Dissection (LPND) at our institution. In July 1990 we performed the first LPND at CAMC (Memorial Division). This report details our experience with the first three patients treated in this manner and suggest that the procedure can be performed safely, effectively, and with a significant reduction in morbidity, thus allowing the surgeon to obtain an adequate specimen for pathologic staging. Possible cost containment, minimal discomfort, and little scarring are other advantages that appeal to both patients and surgeons alike.

Introduction

During the past several years, there have been several advances in the detection and staging of prostatic alignancy. Noteworthy among these developments are transrectal prostatic ultrasound and the advent of the sensitive PSA. However, digital rectal exam, CT scans, bone scans, and PAP have continued to be the mainstay for clinical staging of prostatic malignancy despite their margin of error.

Conversely, pathologic staging is highly accurate, but is frequently bypassed because it requires a laparotomy with associated morbidity and lengthy hospitalization. However, the possibility of pathologic staging via laproscopy offers potential and real advantages in the therapy of adenocarcinoma of the prostate. This report details our experience with the first three patients treated in this manner. The first LPND was performed in July 1990 at CAMC (Memorial Division).

Materials and Methods

All patients had a diagnosis of adenocarcinoma of the prostate confirmed with biopsy and clinically staged to a B1 or B2 lesion. The LPNDs were performed using a technique employing four punctures consisting of two 10mm punctures, one at the umbilicus and one 5 cm above the symphysis pubis, and two 5mm punctures placed 3 cm medial to the anterior superior iliac spine bilaterally.

A small TV camera was attached to the umbilical laparoscope, which transmitted the images to monitors placed on each side of the operating table. Each step of the operation was easily followed via the monitors by the surgeon and his assistant. LPND requires the assistance of a second surgeon trained in this procedure and is crucial for its sucessful completion.

Results

All patients were admitted the morning of surgery and underwent the procedure without complication. The average operating time was 120 minutes, ranging from 90 to 140 minutes. One patient was discharged the next morning and returned to full activity in 48 hours. The other two patients underwent radical retropubic prostatectomy without incident.

The average number of lymph nodes obtained from each iliac fossa was 5.5. In the two patients that underwent subsequent radical retropubic prostatectomy, a minimal amount of lymphoid tissue was found near the bifurcation of the internal/external iliac vessels. In no case did the stage change with the introduction of these additional nodes. One patient, however, was found to have a stage C lesion after final histologic evaluation revealed microscopic metastases to the seminal vesicle.

Discussion

Step sections of all lymphoid and fatty tissue removed with LPND offers very precise information as to the stage of the disease. Preliminary unpublished reports have indicated that many patients thought to have stage A or B disease, are in fact found to have microscopic nodal metastases after final histologic evaluation (1). These patients, obviously, will not be cured with retropubic prostatectomy or radiation therapy.

The outstanding advantage of LPND appears to be ease and reduced morbidity with which pathologic staging can be obtained. The impact of the procedure on the patient's lifestyle is minimal. Since patients return to full, unrestricted activity within an average of five to six days as reported with the laproscopic cholecystectomy (2). This can be expected to result in significant savings, making cost containment a logical and appealing advantage of this procedure. Minimal discomfort and scarring fuel the enthusiasm with which this procedure is being received by the urologic community throughout the country.

In summary, our small series suggests that LPND can be performed safely, effectively, and produce a most adequate specimen for pathologic staging of carcinoma of the prostate. An improved understanding of the biologic behavior of adenocarcinoma of the prostate will subsequently influence the statistical data with respect to radiation and surgical therapy for this malignancy.

Addendum: *Since our original report of LPND, we have successfully performed 17 additional procedures. In each procedure, adequate specimen (i.e. average 5-6 nodes per slide) was obtained for pathologic staging. Operative times have now been reduced to less than 60 minutes. There were no operative complications nor were there any false positive or negative pathologic findings.*

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Medical Grand Rounds

Marshall University School of Medicine

Pressure Sores: An Overview and Update

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Abstract

Pressure sores are expensive and difficult to tream complications of immobility and the incidence of these lesions will increase as the population ages. Modalities for prevention and treatment are numerous but physicians often are not familiar with products available and lack a systematic approach to patients with pressure sores. This paper reviews factors involved with the formation of pressure sores and treatment modalities currently available.

Introduction

Few problems confronted by physicians in the care of the chronically ill are as frustrating as pressure sores. These troublesome complications of immobility are frequently blamed on poor nursing care, yet simultaneously physicians defer to nurses' judgment in regard to appropriate treatment. We as physicians, however, can and should offer our patients much in regards to both prevention and treatment of pressure sores.

Previously called bedsores or decubitus ulcers (from the Latin "decumbere" - "to lie down"), these lesions are now called pressure sores, a term that more accurately connotes the primary pathogenesis. The development of a pressure sore adds at least $10,000 to the cost of a single episode of care (1), including the costs of dressings, extra nursing care, rehabilitation, and nursing home care that might not have otherwise been necessary.

Demographics

Pressure sores develop in 3 percent to 4.5 percent of all hospitalized patients, usually within the first week of hospitalization. Thirty-five percent of nursing home patients will have pressure sores at some time, but their prevalence rate at any given time in nursing homes is usually between 3 percent and 6 percent. Eighty-five percent of spinal-cord-injured patients develop pressure sores, and 7 percent to 8 percent of the deaths of these patients can be attributed to complications of the sores (2). The prevalence of pressure sores in community-dwelling elderly people is very low, less than .04 percent (1).

Host Factors

Advancing age is a risk factor for pressure sore development. In most studies, only 15 percent to 17 percent of pressure sores occur in persons under 50 years of age, and the vast majority in this younger age group are in spinal-cord-injured (SCI) patients. Victims are invariably mobility impaired; one series reported 53 percent being totally bedridden, 37 percent wheelchair-confined and about 10 percent ambulatory only with assistance (1).

The most common diagnoses associated with pressure sores are atherosclerotic cardiovascular disease, stroke, congestive heart failure, renal insufficiency, cancer, and hip fracture. Spinal cord injury in and of itself does not cause a predisposition to pressure sores; unrelieved pressure causes skin ulcer formation in SCI patients by the same mechanism operative in non-SCI patients.

Malnutrition as manifested by hypoalbuminemia is one of the most important host factors that places patients at risk for pressure sores. Gorse and Messner studied patients at the Veterans Administration Medical Center in Huntington, and found that patients with pressure sores had average albumin values of 2.82 g/dl compared with 3.48 g/dl in the patients who did not develop pressure sores (3).

Other important host factors include incontinence, altered state of consciousness, and loss of cutaneous sensation. For example, devitalized tissue, such as tissue damaged by repeated intramuscular injections of medication, is at high risk for the development of pressure sores.

In addition to the host factors which contribute to the formation of pressure sores, four processes are involved in their pathogenesis: 1) pressure; 2) shearing forces; 3) friction; and, 4) moisture.

Pressure

The arterial limb of a skin capillary maintains an average pressure of about 32 mm Hg. The mid-capillary pressure is about 20 mm Hg and the venous limb capillary pressure is only 12 mm Hg (1). With the application of external pressure, the interstitial fluid pressure increases, rather easily exceeding 12 mm Hg and ultimately leading to filtration of fluid from the capillaries, edema formation, and occlusion of lymphatic vessels. This disturbance in the microvasculature results in poor tissue oxygenation, accumulation of anaerobic metabolic waste products, and tissue necrosis. Figure 1 shows the relative pressures encountered by body tissues in several circumstances. Irreversible tissue damage occurs after two hours' continuous application of pressures above 70 mm Hg.

Pressure applied to the skin is transmitted through the tissue in a cone-shaped distribution, with a bony prominence being the base of the cone. This accounts for the predictable appearance of pressure sores over the trochanters, the crista mediana of the sacrum, the scapulae, and the heels, all areas where bony prominences have little overlying muscle or subcutaneous tissue to absorb and diffuse pressure.

Shearing Force

By definition, shearing force is caused by sliding of adjacent surfaces of laminar elements which provides a progressive relative displacement of the elements. Clinically, shearing occurs when loose superficial tissues slide over the firmly attached deep fascia, causing stretching and angulation in vessels (5). The shearing force contributes to undermining of ulcers. This pathogenetic factor develops when the head of the immobile patient's bed is raised and gravity pulls on the limbs and trunks (Figure 2).

Friction

Friction, the next important feature in the pathogenesis of pressure sores, removes the stratum corneum, the outer protective layer of skin. In a clinical situation, this occurs when patients are dragged across the bed rather than being lifted or being rolled.

Moisture

Moisture, for example from incontinent urine or feces, perspiration, or wound drainage, increases the risk of ulceration about five-fold. A recent study showed that urinary incontinence was less a risk than fecal incontinence (Table 1). The investigators evaluated 27 different patient characteristics in approximately 600 hospitalized patients. They identified 108 patients as having high likelihood of developing pressure sores by virtue

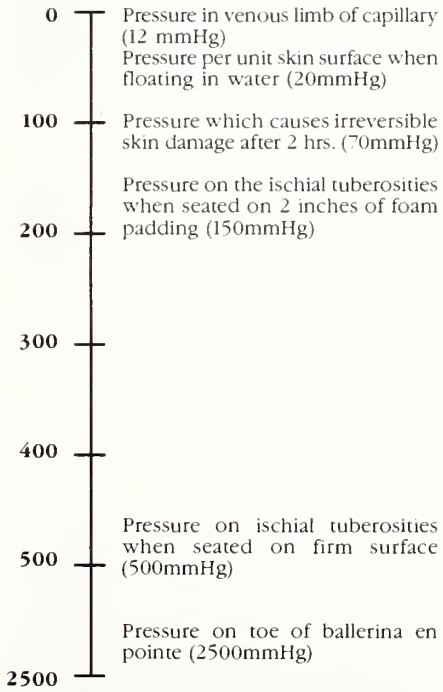
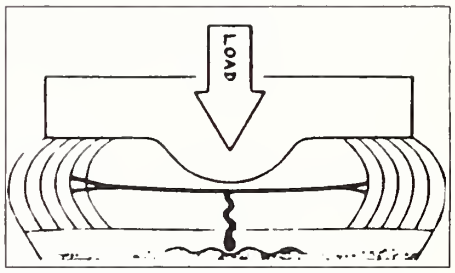
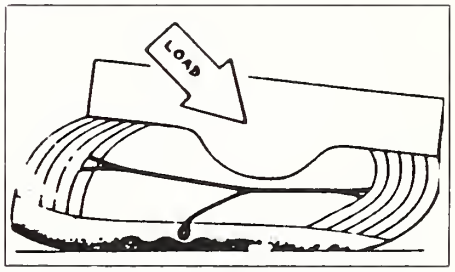


Figure 1. Pressures on various tissues



Distortion of "tissues" with patient lying down.



Distortion of "tissues" with patient semi-recumbent.

Figure 2. Distortion of tissues in supine positions. (From Scales, *Care Science & Practice*, 1982.)

Table 1. Clinical Characteristics of 108 Patients at Risk for Pressure Sore Formation			
Characteristic	**PTS W/ Sores (N=30)**	**PTS W/No Sores (N=78)**	**p Valve**
Fecal Incontinence (%)	73	41	0.0005
Diarrhea (%)	43	20	0.02
Fracture (%)	17	4	0.02
Malignancy (%)	10	29	0.03
Spinal Cord Injury (%)	10	5	0.39
Stroke (%)	10	15	0.47
Urinary Incontinence (%)	24	26	0.85

(From Allman, et al. *Ann Intern Med* 1986; 105:337-342.

Table 2. Summary of Adjunctive Studies in Evaluating Bone Underlying 28 Pressure Sores				
	Osteomyelitis Present		**Osteomyelitis Absent**	
Type of Study	**Positive**	**Negative**	**Positive**	**Negative**
Roentgenogram	4	4	4	14
Technetium Tc 99m medronate bone scan	9	0	8	8
Gallium citrate GA 67 scan	5	1	7	10
Bone cultures	8	0	12	6

(From Sugarman, *Arch Intern Med* 1983; 143:688.)

of having been confined to bed for a week or more; and of the 108 patients in their study group, 78 were at risk but had no pressure sores, and 30 patients had developed sores. The most significant factor differentiating "at risk without sores" from "having sores" was fecal incontinence (6).

Differential Diagnosis

An ulcerated area over one of the regions of bony prominence can usually be clinically diagnosed as a pressure sore. The differential diagnosis is not extensive; however, some disorders need to be ruled out. For sacral ulcers, the possibility of perirectal abscess must be considered. In bedridden patients with rheumatoid arthritis, vasculitic ulcers may be confused with pressure sores. On occasion, deep mycotic infections can appear as pressure sores. Primary cutaneous or metastatic malignancies may mimic pressure sores, and malignancy rarely develops in pressure sores. A pressure sore that is not healing well with appropriate treatment, especially if it has a verrucous border, should be biopsied to rule out malignancy.

Evaluation and Classification

Shea's classification scheme offers the most clinically useful means of grading the severity of pressure sores (7). A Grade 1 pressure sore is an acute inflammatory response primarily in the epidermis, with minimal soft tissue swelling and warmth; it is erythematous, and unless it is abraded, the erythema will blanch. Usually it is very discretely bordered. A Grade 2 pressure sore is an inflammatory and fibroblastic response extending through the epidermis into the dermis and sometimes into the subcutaneous fat. A Grade 3 pressure sore clearly penetrates into the subcutaneous layers; often exposing muscle, fat and tendons. A Grade 4 pressure sore extends beyond the deep fascia, almost always to the bone, and sometimes includes fistula formation.

Appropriate classification is of course necessary to ensure adequacy of treatment. Several investigations may need to be done, the first of which is careful physical examination, with palpation of wound edges to determine the extent of any undermining. If the lesion is ischial or sacral, a rectal examination is necessary.

Radionuclide imaging can prove very useful in evaluation of grade 3 or 4 pressure sores; technetium bone scans and gallium scans may be necessary to rule out osteomyelitis. Table 2 shows the sensitivity and specificity of different scans and radiologic procedures (8). All of the studies are relatively sensitive, except for plain x-rays which have only 50 percent sensitivity. Technetium bone scans and gallium scans detect most of the bone lesions that eventually prove to be infected. No test, however, is highly specific, false positives occurring with all procedures. Another occasionally useful radiologic procedure is the sinogram, which is indicated if sinus tracts are suspected.

Biopsies are indicated for two circumstances: first, skin biopsy to rule out malignancy in suspicious lesions, and second, bone biopsy when osteomyelitis is suspected. Bone biopsy specimens must be sent for culture and for histologic examination.

Wound cultures must be properly collected to be helpful. Surface swabs are not useful as essentially all pressure ulcers are surface colonized, usually with a variety of organisms including Staphylococcus and gram negative bacteria. Aspirated

specimens from the erythematous edge may be obtained, but the yield is fairly low. Ideal for culture is the purulent drainage sometimes encountered in the course of debridement.

Culture of every bone biopsy specimen is necessary, but isolation of organisms is not sufficient for establishing an absolute diagnosis. In 1983, Sugarman reported a series of 18 bone biopsies, 12 of which yielded positive cultures, but lacked histologic evidence of osteomyelitis (8). Possibly during the course of the surgery, these specimens are contaminated by organisms from the sinus tracts; therefore, a positive culture alone without evidence of inflammatory response in the bone is not adequate for an unequivocal diagnosis.

Complications

Mortality is nearly 40 percent in patients who develop a pressure sore-related infection, and it is highest in patients over 60 years old. Patients with multiple lesions, not surprisingly, have a higher case fatality rate than patients with single lesions (54 percent vs. 18 percent) (1).

Osteomyelitis is the most common infection, accounting for two-thirds of all infections. When bone is proven infected by histologic exam, treatment is chosen according to the culture results. Sugarman found that seven of eight bone cultures with histologic proof of osteomyelitis had at least two organisms (9). Usually the infecting organisms are anaerobes, Pseudomonas, and Enterococcus.

Sepsis is a serious potential complication. Chow in 1977 reported deaths, 19 because of sepsis (9). More than one-half of those infections were polymicrobial with Bacteroides, Peptococcus, Peptostreptococcus and Proteus the predominant organisms. The most common organism isolated from surface swabs and aspirates is Staphylococcus; however, it is the least common cause of septic death.

Another common infectious complication is cellulitis. Cellulitis requires systemic antibiotics for control; topical antibiotics should not be used. Less commonly occurring but more serious is "phagedena." This is a general term for several clinical syndromes which involve deep gangrenous skin ulcers with progressive tissue invasion, including necrotizing fasciitis, clostridial myonecrosis, and synergistic necrotizing cellulitis of Stone and Martin. Definitive surgery is mandatory.

Pressure sores are tetanus prone and patients who present with an unclear history of immunization should receive tetanus toxoid and human tetanus immunoglobulin. It is likely that elderly women and older non-veteran men have not had adequate tetanus immunization.

Non-infectious complications of pressure sores include amyloidosis, which occurs fairly commonly, and occasionally renal and bladder stones, hydronephrosis, and urethral and bladder diverticuli. Immobility may be the common factor linking pressure sores to these conditions.

Prevention

Since pressure sores, even small ones, are very difficult to eradicate, prevention is the first line of care. Meticulous nursing care is required to prevent pressure sores in immobile persons. Patients should be turned frequently, never remaining more than two hours in any one position. There should be no pressure, ever, on an active sore.

To "prevent" ulcers, many forms of special bedding are marketed. However, without proper turning and positioning of the patient, none of these beddings are of substantial benefit. Water mattresses may be a valuable adjunct to nursing management, but air mattresses should <u>not</u> be used, as they are too firm and too hot. The silicone gel wheelchair pad is a useful assistive device. "Egg-crate" mattresses are a good form of super-soft bedding and are relatively inexpensive. However, their use is prohibited in the VA system and in some states, because if burned they release toxic fumes.

No benefit of vasodilators or external massage has been established. So called "donuts" should not be used; they do take the pressure off the sore itself but simultaneously exert equivalent pressure to adjacent tissue, and may thereby increase tissue ischemia in the already damaged area. The best method of preventing shearing force is to place the patient's feet against a footboard and use foam wedges to elevate the head, rather than cranking up the head of the bed. Adverse effects of friction can be prevented by having patients lifted and rolled. Patients with movement disorders, including Parkinson's Disease and Huntington's Chorea are at increased risk of friction damage to their skin and some benefit is attained by decreasing spasticity when this is possible.

As moisture is an important contributor to development of pressure sores, sheepskins may help by reducing body heat and perspiration. Incontinent patients may do better when they are cleaned with shaving cream rather than soap and water, the emollients in the shaving cream offering some protection against friction.

Finally, maximize the nutrition of patients with pressure sores, minimize sedation and optimize control of other underlying medical conditions.

Therapy

The goal of therapy is to completely restore the microcirculation. Principles of therapy include pressure reduction, debridement of necrotic tissue, local disinfection and appropriate wound dressing.

Two special "fluid" beds have been developed for the treatment of patients with pressure sores; the low-air-loss (Mediscus®) bed and the air-fluidized (Clinitron®) bed. These consist of compartmented "cells" in which circulating air alone, or ceramic beads pumped by air pressure, create a fluid surface upon which the patient rests. Table 3 shows the substantial advantages of special beds based on the results of a 1987 study conducted at Johns Hopkins (10), which showed that healing of pressure sores proceeds better when air fluidized beds are used. The disadvantages are exceptionally high cost, the dehydrating effect of constantly moving air, and lack of a firm surface to support the patient during coughing or attempts at self-movement.

Debridement of all necrotic tissue is essential also. Lesions should be

Table 3. Outcome of Pressure Sores with Air-Fluidized Bed Therapy and Conventional Therapy

Outcome Measure	Air-Fluidized Bed Therapy (N=31)	Conventional Therapy (N=34)	p Valve
Changes in total surface area, cm^2			
Median	−1.2	+0.5	0.01
Range	−38.0 to +15.5	−55.1 to +94.7	
Patients improved, masked clinical assessment, n	22	16	0.05
50% reduction in total surface area, n	9	8	0.64

(From Allman, *Ann Intern Med* 1987; 107:643.)

Table 4. Topical Preparations Used in Treatment of Pressure Sores

1. Saline, Ringer's or Dakin's Solution for wet-to-dry dressing
2. Granulated sugar
3. Dextrose beads (Debrisan[R])
4. Starch microgranules (Bard[R])
5. Liquid antacids
6. Gelfoam[R]
7. Karaya gum
8. Zinc oxide
9. Balmex[R]
10. Granulex[R] (Trypsin, Balsam Peru, Castor oil)
11. Enzymes
    a. Collagenase (Santyl[R])
    b. Fibrinolysin and Desoxyribonuclease (Elase[R])
    c. Streptokinase—Streptodornase (Varidase[R])

Table 5. Available Occlusive Dressings

Films:	Op-Site[R], Tegaderm[R]
Foams:	Synthoderm[R], Epiloch[R]
Hydrocolloids:	Duoderm[R], Comfeel[R]
Hydogel:	Vigilon[R]
Calcium Alginate:	Sorbsan[R]

debrided by sharp dissection until bleeding is encountered. Newly debrided wounds should be packed, preferably with saline wet-to-dry dressings. The black eschar sometimes adherent to pressure sores cannot be debrided at the bedside. However, bedside debridement may be possible if these areas first are crosshatched with a scalpel and an enzyme preparation applied to digest the eschar. Table 4 lists a number of the available debriding preparations. Some are enzymes and some are designed to absorb exudates including purulent drainage, while others are combinations. They are all somewhat effective; however, the commercial preparations are quite expensive. The studies to date of absorbent agents and enzyme preparations, except for a very few, are uncontrolled and therefore recommendations on the relative usefulness of the agents cannot be made from a literature review.

Local disinfection can improve healing and allow earlier surgical closure, if surgery is indicated, by reducing the bacterial count of the tissue to less than 10^5 organisms per ml of tissue (4). The hazard of local disinfection lies in the potential for antiseptics (e.g., iodine compounds or merthiolate) to kill new epithelial cells. Consequently, they must be used with care and discontinued when granulation is seen. Topical antibiotics must not be used.

Finally, wound dressings are needed which create physiologic conditions conducive to granulation tissue formation, i.e., epithelial mitosis and migration. It is probably important that the dressing be moisture-vapor permeable, as totally occlusive dressings may lead to increased infection, and the dressing should permit the wound area to maintain a near normal temperature for maximum granulation. The ideal dressing would also be transparent so that the wound could be observed for signs of infection, and absorbent to allow removal of any exudative or necrotic debris. Adhesiveness is desirable as this would help prevent additional shearing force or friction.

Table 5 shows the various dressings that are available. In one of the few controlled studies, healing was enhanced by use of hydrocolloid dressing, compared with standard therapy (3). Some wound exudation occurs under a hydrocolloid dressing, but without other signs (such as fever or adjacent skin erythema), exudate alone does not imply infection.

The newest ulcer dressings on the market are manufactured from alginic acids, naturally-occurring polymers found in brown seaweed cell walls. A non-woven calcium alginate fabric has been developed (Sorbsan[R]) which shows great promise in treatment, especially for exudative pressure sores. This material gels upon contact with the exudate, and "wicks" the exudate away from the wound surface into an overlying absorbent dressing. The gel is rinsed away with saline at the time of dressing changes, thereby greatly increasing patient comfort, compared to other debridement measures.

Other modalities of treatment include various physical therapies such as drying the tissue with an infrared lamp or ultraviolet light, whirlpool with antiseptic for local disinfection, and hyperbaric oxygen. No consistently beneficial results have been demonstrated with any of these treatments, though whirlpool treatment is attractive for its ability to debride necrotic tissue. Laser

therapy is available in some centers and it may prove useful. Nearly all grade 4 and some grade 3 lesions require surgical intervention. In addition to operative debridement, which is occasionally necessary, skin grafts are needed frequently and sometimes rotation of very large flaps of skin is required.

Summary

In conclusion, a review of available therapies suggests that the following approach to treatment would be successful in most pressure sores: Grade 1 lesions will respond to removal of pressure; a hydrocolloid dressing may be applied if there is any area of skin abrasion. Grade 2 ulcers should be approached by total relief of pressure and debridement if necessary. Wounds should be packed with ¼ strength Dakin's solution or saline wet-to-dry dressings, or calcium alginate dressings, until granulation appears. Then hydrocolloid dressing may be useful until full re-epithelialization has occurred. Grade 3 lesions need all the modalities of treatment as described for grade 2 lesions, plus evaluation and treatment for osteomyelitis if present. Grade 4 ulcers will require surgical intervention. Exudative sores of any grade may benefit from use of calcium alginate dressings until the exudate clears. Patients who do not have documentation of immunization should receive tetanus toxoid and human tetanus immune globulin.

Pressure sores are almost invariably preventable when caregivers understand principles of pathogenesis. Given an understanding of basic principles and a meticulous staff to apply the care, treatment of pressure sores can also be accomplished effectively.

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Manuscript Information

Manuscripts to be presented for publication in the *West Virginia Medical Journal* should be prepared in accordance with "Uniform Requirements for Manuscripts Submitted to Biomedical Journals" (1) (International Committee of Medical Journal Editors).

The *West Virginia Medical Journal* will not consider for publication a paper or work that already has been reported in a published paper, or is described in a paper submitted or accepted for publication elsewhere.

Manuscripts, accompanied by one copy, should be typewritten, double-spaced, on one side only of white bond paper (8½ by 11 in.), with margins of at least one inch.

Use double spacing throughout, including (in the following order) title page, abstract, text, acknowledgements, references, tables, and legends for illustrations. Begin each of the following sections on separate pages: title page, abstract, text, acknowledgements, references, individual tables, and legends for illustrations. Number pages consecutively, beginning with the title page. Type the page number in the upper right-hand corner of each page.

Articles contained on computer diskettes are acceptable and encouraged. Please contact the *Journal* in advance to determine the format type to be used. The conventional manuscript as described above must accompany the diskette.

All persons designated as authors should qualify for authorship. Each author should have participated sufficiently in the work to take public responsibility for the concept.

The second page should carry an abstract of no more than 150 words summarizing the manuscript.

Where reference is made to generically-designated drugs, the first such reference must be followed by parentheses containing the most commonly known trade-name drug of that designation. In addition, a listing of all generic drugs mentioned in the article, with their trade-name equivalents, should appear at the end of the article.

Tables (tabular listings) and figures (photos, drawings and charts) should be numbered and the point of reference in the text indicated in parentheses, i.e., (Table 1), (Figure 1).

Photos must be good-quality unmounted glossy prints usually 5 by 7 in. but no larger than 8 by 10 in. Black and white photos are preferred. Color photos will be printed in black and white. Cost of printing photos in excess of four will be billed to the author.

Each photo (figure) should have a label pasted on its back indicating the name, its number and an indication of its "top." A separate legend should be provided for each photo. Do not write on the back of photos, or scratch or mar them using paper clips. Do not mount them on cardboard. Drawings and charts should be done in solid black on pure white.

Number references consecutively in the order in which they are first mentioned in the text. Identify references in text, tables, and legends by arabic numerals (in parentheses).

No more than 25 references will be published free of charge to the author.

Use the style of references seen in this *Journal,* which is based on the formats used by the U. S. National Library of Medicine in *Index Medicus.* The titles of journals should be abbreviated according to the style used in *Index Medicus.* Consult "List of the Journals Indexed," printed annually in the January issue of *Index Medicus.*

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1. Ann Intern Med 1982;96:766-71.

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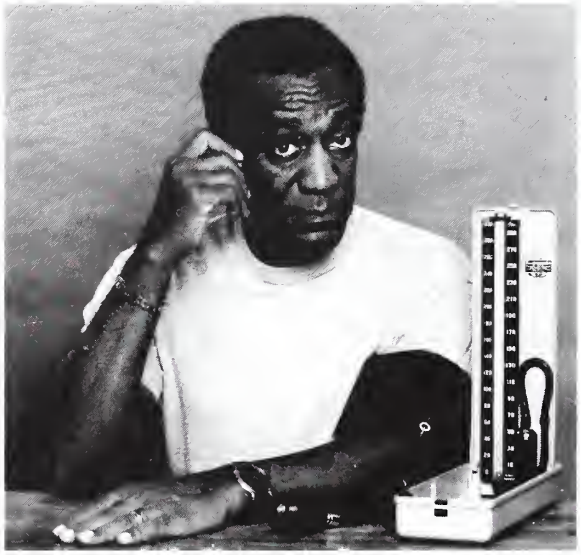

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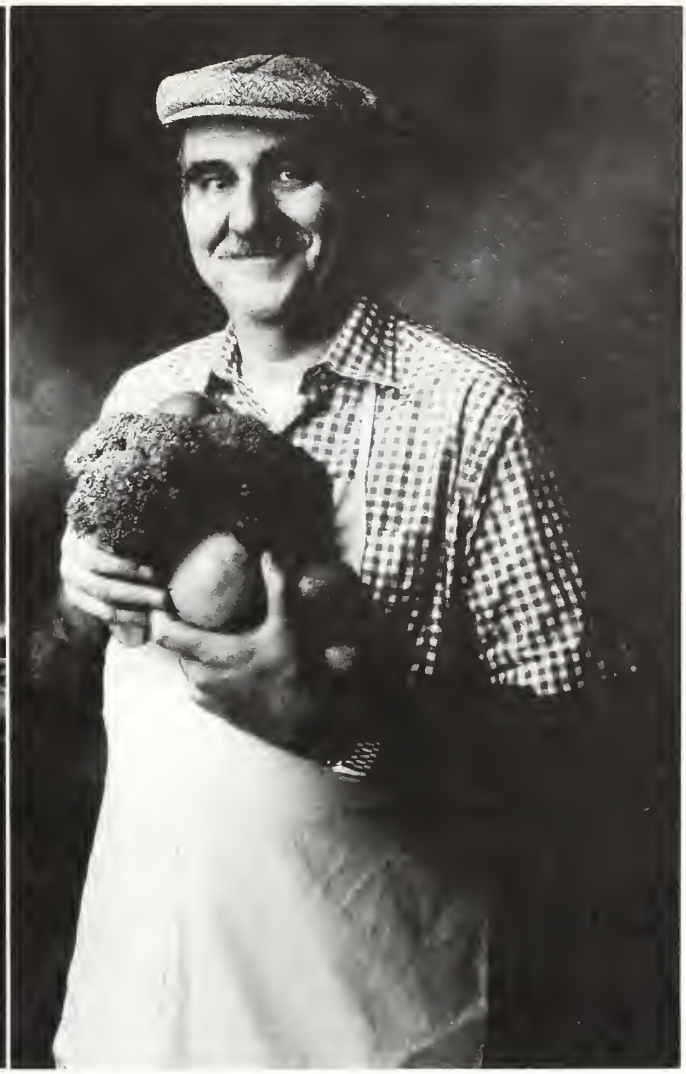

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President's Page

Michael M. Stump, M.D.

Some Good Things Happen

The regular West Virginia Legislative Session is now over. During the past six months, the WVSMA grew up a bit in the real world of politics.

We fought against bills that would have harmed our patients as well as hurt our profession. We helped block, defeat or modify those bills. Noteworthy was the defeat of HB 2858 and SB 485, which had portions granting prescriptive powers and independent practices to lay midwives, nurse midwives and nurse practitioners without any physician supervision or input. We also fought off an attempt by pharmacists to prescribe drugs as proposed in HB 2930.

We fought for those bills or sections of bills that were helpful to our patients or to us. The "take one, take all" portion of old SB 576 has been deleted by HB 2979, although the PEIA "ban on balance billing" remains. This effectively removes the penalties for non-compliance. The health care planning commission bill, HB 2461, was properly modified to planning and study with its implementing authority removed. The WVSMA still wants a seat on this commission.

Tail coverage on liability insurance must now be offered on claims-made policies and payment may be amortized over a 36-month period. Health service organizations such as Blue Cross and Blue Shield must now participate in an improved Guaranty Trust Association to cover defaults. They must also maintain a $2 million surplus and comply by October 1, as well as provide an annual financial statement and be financially examined every three years.

Our 11 tort reform bills were introduced during this session but received no action. Tort reform may ultimately require congressional action on the federal level, such as passage of the recently introduced Hatch-Johnson Bill. In the meantime, we will sit down with the West Virginia Trial Attorneys Association to search for any common ground in this matter.

How were these objectives accomplished? They were achieved by firmness of purpose; by unyielding dedication to our patients; by some careful plans and concepts; by cooperation, hard work and reasonable compromise; by willing participation of physicians who all responded as asked; by outstanding efforts from our auxiliary members who also ran phone banks and made key legislative contacts; and by our lobbying staff who frequently went without enough sleep during the final days.

I believe the WVSMA made more friends than enemies in many legislative and non-legislative arenas. We gained a measure of respect as being willing and able to fight hard for what we believed in and to be reasonable at the same time. Soon we will join with various members and committees of the Legislature to work on a number of health issues.

In addition to continuing to support the expansion of the wellness effort, the WVSMA will introduce or refine other initiatives. We will work with members of the Legislature to explore various options on Medicaid funding, a physician-midwife-nurse practitioner team approach to benefit rural mothers and other patients, and an indigent care plan that integrates preventive medicine standards as reported in last month's *Journal*.

We want to investigate extending the physician-originated concept of voluntary local free clinics into a state-wide program of local efforts on behalf of the poor. This will involve health care providers, community volunteers, community organizations, and hopefully state-funded supplies and medications, along with liability relief for volunteers, which would include retired physicians.

In a separate effort, we will evaluate and investigate certain proposed rural health care concepts and programs.

Our willingness to be involved in solving some of the health problems facing our state is critical to the WVSMA. If we fail to get involved now in the attempt, we shall certainly deserve the loss of respect that will assuredly follow so great a neglect.

I believe deeply in the WVSMA and our auxiliary. I know we can work together and reason with our legislators and others to help patients.

I know we can. I know we will.

Michael M. Stump, M.D.

Editor's Note: *Dr. Stump's February message "In Defense of Freedom," has been reprinted as a guest editorial in the March 15 issue of Illinois Medicine, the journal of the Illinois State Medical Society.*

Competition

Competition in medicine is what Congress wanted in the 1960s and 1970s. If we can only get enough doctors out there competing for a set amount of business, our good old free enterprise system will do the rest. Medical care prices are bound to fall, they thought.

However, several things happened to upset the calculations. It turns out that there is no such thing as a set amount of medical business — the more doctors available, the more people are likely to visit them. Then, too, someone forgot to turn off research and innovation in computers, electronics and such. Utterly fascinating technologic devices were made available to the increased supply of doctors who, in turn, found they could diagnose and treat more conditions and more diseases, much earlier and thus much longer than had ever before been considered possible.

A third misfortune befell the medical economists when they began worrying aloud about the high costs of all the amazing high tech equipment and the rising percentage of the GNP being consumed by medical care. Better PR and better marketing could not be bought at any price. The public soon got the idea that, "if that guy down the street had one of those tests, I'm going to have one too" or, "I'm not sure what a GNP is but if it has something to do with money, I'm going to get my share." The newly increased supply of doctors was suddenly besieged with demands by new patients for expensive new tests.

An unexpected disaster occurred to the medical economists when everyone's friend, the plaintiff attorney, began convincing jurors that any prior omission of high tech diagnostic capabilities is prima facie evidence of negligence and culpability for failure to diagnose anything at any time in the future. Those doctors who, out of a sense of pride, plain old conservatism or a frugal nature, continued to rely on those techniques learned in their medical school classes on physical diagnosis, were in hot water and rapidly began to change their ways.

Our government, aware at last of the money-eating monster it had engendered, took very predictable governmental action to control the monster. It created a bureaucracy to control medical costs. In self-defense, private medical insurers were forced to clone government program efforts at discounting and utilization review. Administrative costs of the medical care system are now recognized as the most rapidly escalating component of medical care costs.

Failing hospitals, doctors leaving the practice of medicine or retiring early, unhappy patients, indignant taxpayers, frustrated congressmen but contented legions of bureaucratic employees secure in their lifetime job of harassing doctors are the result.

It somehow just does not seem right. Something went wrong back there but, pray God, let's not ask the government to fix it. Maybe it is just competition, but if it is, we've had about all of that we can stand.

—SDW

Medical System in Danger of Being Destroyed

We cannot say the West Virginia Legislature is afraid to tackle the really tough health care issues -- both houses have passed laws dealing with the burial of dead chickens. Of course, the versions differ and a conference committee will try to effect a compromise.

Nor can we say they are anti-business -- after all, they have taken great pains to keep from harming the cockfighting raising and training industry (cockfighting is illegal.) But the number one industry in this state, in terms of number of jobs, is health care, and the governor, if not the Legislature, is out to gut the industry.

One example is the West Virginia Health Care Commission Act (SB 296 and HB 2460). This act establishes a seven-person commission, based in the governor's office, with all members appointed by the governor. Five of the seven members will have no knowledge or expertise in health, insuring a rubber-stamp for the governor's idea. Ignorance of health care matters is no vice but is it a virtue if it is your job. One of the governor's previous ideas, SB 576, passed last year to increase access to medical care (the "take one, take all" plan) has resulted in decreased access since 42 physicians, 11 of them obstetricians, opted out entirely and 135 other physicians (5 percent of the total) left the state.

The number of physicians delivering babies in West Virginia has fallen from 300 to between 50 and 60. Not to worry, however, we now have SB 485, the midwifery bill. This would be a step back to the 19th century, except that certain provisions seem more like the 17th. It would mandate state licensure for untrained midwives. In other words, you do not need to know how babies are made or where they come out to obtain a license to deliver them. If there are no educational requirements, presumably anyone, male or female, can be a midwife. It follows naturally, that if anyone with no knowledge can pass health legislation, you really do not need an education to be a doctor. While the actual birth can be pretty bloody, scary and dangerous, 95 percent of the work is prenatal care, so if you are out of a job, enjoy working with young women, enjoyed playing "doctor" as a child, maybe you should consider a career in West Virginia midwifery.

If the governor succeeds in driving all the best physicians out of West Virginia, don't worry, just do like the governor, go to Cleveland for your "colds" and on one of his Japanese junkets, he'll come back with a whole boatload of physicians. If they do not speak English, don't worry. First, you can deliver babies just fine without a word of English and they will be more complaint with the state's "rules" for medical care.

The current debacle over the medical schools provides yet another example. There was zero input on this legislation from the medical schools themselves or from the medical profession. Would they try that trick on organized labor or the mining industry? The stated goals of the Legislature, "a doc in every small hamlet," is the medicine of the 1950s, not the 1990s.

We have the best medical system in the world. Foreigners do not come to this country to see how we make steel, aluminum, cars or televisions but they come to study our medical system, a system being destroyed by the central planners -- Embracing planning and control, just as Russia and Eastern Europe have proven its bankruptcy.

Wallace D. Johnson, M.D.
Beckley

Editor's Note: *This letter appeared in the Beckley Register-Herald on March 3 and since that time new developments have occurred with some of the legislation Dr. Wallace mentions. While the cockfighting bill was passed by the Legislature, both HB 2858 and SB 485 relating to midwifery were defeated. Also, one major provision of old SB 576 regarding the take-one, take-all requirement was removed this legislative session in HB 2979.*

In My Opinion

The Medical Dichotomy: Malpractice

Whom do the insurance companies and lawyers think they are kidding? They have driven America to the verge of socialized medicine.

The disillusionment of the public from the grossly and outrageously exploited cases of malpractice has permanently damaged the health care industry. This has also increased both the number of malpractice lawsuits and the amount of insurance premiums for all physicians and patients. The imperfect physicians are now wary of every patient who is treated because of possible litigation that might ruin their careers, and the widespread occurrence of malpractice lawsuits has forced insurance companies to raise premiums to exorbitant levels. Overall, the lawyers and insurance companies have split the health care industry and greatly reduced the availability of the superb care America has grown to expect. This is evidenced, for example, by a 20 year low in applications to medical school while college enrollment is increasing.

During the last decade, the number of medical malpractice suits has increased exponentially. Has the quality of health care in America deteriorated to that degree? The billion-dollar research facilities, miraculous organ transplants, new pharmaceuticals, and myriad other advancements suggest otherwise. Complications that were formerly blamed on God are now accredited to physicians' negligence. An over-abundance of graduating attorneys prompted the naive public to look toward the proverbial "rich doctor" as a means of income. Rarely does the physician receive any gratitude for a miraculous surgery that enables a person to walk or talk after an accident. Instead, the patient is encouraged by an attorney to file a lawsuit against the physician for a normal complication.

There have been cases in which lawyers solicited patients in the hospital to scope possible lawsuits. The patient is provided an impetus to sue by the contingency fee system offered by lawyers in which the patient is only required to pay the attorney in victorious cases. With nothing to lose, the misinformed patient views this opportunity as a chance to win the lottery. The victimized physician is then placed at the mercy of a jury with no aptitude or expertise to judge the medical aspect of the case.

The public, attorneys, politicians, and media would be shocked if physicians developed a similar contingency fee concept. What if a doctor loses a patient and the family is not charged? However, if the doctor fixes a Heisman Trophy winner's knee and thus allows him to progress to a professional career, he collects 40 percent of the player's NFL contract earnings.

What if a baby is successfully delivered and the physician receives a percentage of the baby's lifetime earnings, or a multimillionaire is enabled to live by a cardiac bypass and is billed 30 percent of his entire estate? This is as ludicrous as the legal contingency fees whereby a lawyer receives 40 percent of a large settlement and the paralyzed patient only gets 60 percent.

The increasing number of cases decided against physicians has outrageously enlarged their malpractice insurance premiums and, in turn, the fees charged to patients. The insurance companies are forced to increase premiums to cover the losses of unsuccessful lawsuits. Some physicians in West Virginia face annual premiums above $125,000. This has caused some physicians, especially obstetricians, to abandon their practice or to move to a state with lower premiums. It is ironic that as the lawsuits drive off obstetric physicians, the federal government is allocating money to train midwives. As we approach the 21st century, childbirth will be Little House on the Prairie—revisited.

The higher incidence of malpractice suits has also greatly diminished the number of competent physicians in rural areas, and now patients are forced to travel great distances to receive treatments they need. The high percentage of lost lawsuits prompted insurance companies to reimburse fewer and fewer medical procedures while maintaining high premiums and raising the deductibles. Does the consumer expect to pay K mart prices for a Bloomingdale fur? Obviously not, but the insurance companies are attempting this bargaining procedure with the physicians' fees. Regardless, at least one major insurance company, WV Blue Cross and Blue Shield Inc., has been driven into bankruptcy by this turbulent cycle brought on, in part, by the litigious attorneys and patients.

Whom are the insurance companies and lawyers actually kidding? The public has been given many misconceptions and physicians have been placed in a no-win situation. The citizens who receive major settlements as a result of winning a malpractice lawsuit jeopardize the health care of the rest of the public as a result of that winning. Some top-rated physicians have become very selective in accepting or rejecting cases while some recent medical graduates have been forced to enroll in health plan organizations that corner the medical market. Therefore, the public may be subject to the lesser-trained physicians who are more likely to exhibit a true case of malpractice. This heightens the potential for major litigation and further hampers the health care industry.

America has been pushed to the limit of consideration of Senator Rockefeller's first year projection of $60 billion for the Pepper Commission's recommendations. This type of structured nationalized health care could push the U.S. into an economic tailspin. The American public should realize the intrinsic problems of a socialized medicine system that would ultimately be devised through the efforts of attorneys, insurance representatives, and government bureaucrats, all untrained in complicated modern science. The system is currently being rejected by various countries. For instance, patients in England and Wales are placed on waiting lists of up to four years for elective procedures. The top quality students will not undertake 25 years or more of rigorous education and expenses as evidenced in England and then be subjects of a bureaucratic system.

A greater public awareness is needed to recognize and rectify the damage to the health care industry in America caused by the insurance companies, attorneys, and plaintiffs looking for a big time, lottery-like win.

Brian Caveney
Wheeling

Editor's Note: *Brian Caveney is a 17-year-old Wheeling senior who was just named a White House Presidential Scholar semifinalist for being among the top 1,500 U.S. students in SAT scores. Brian is one of the state's five Foundation Scholars this year and will be attending WVU on a full scholarship. In addition, he has been selected as one of the 30 graduating high school students in the nation to participate in a special exchange program this summer where he will study traditional medicine in China.*

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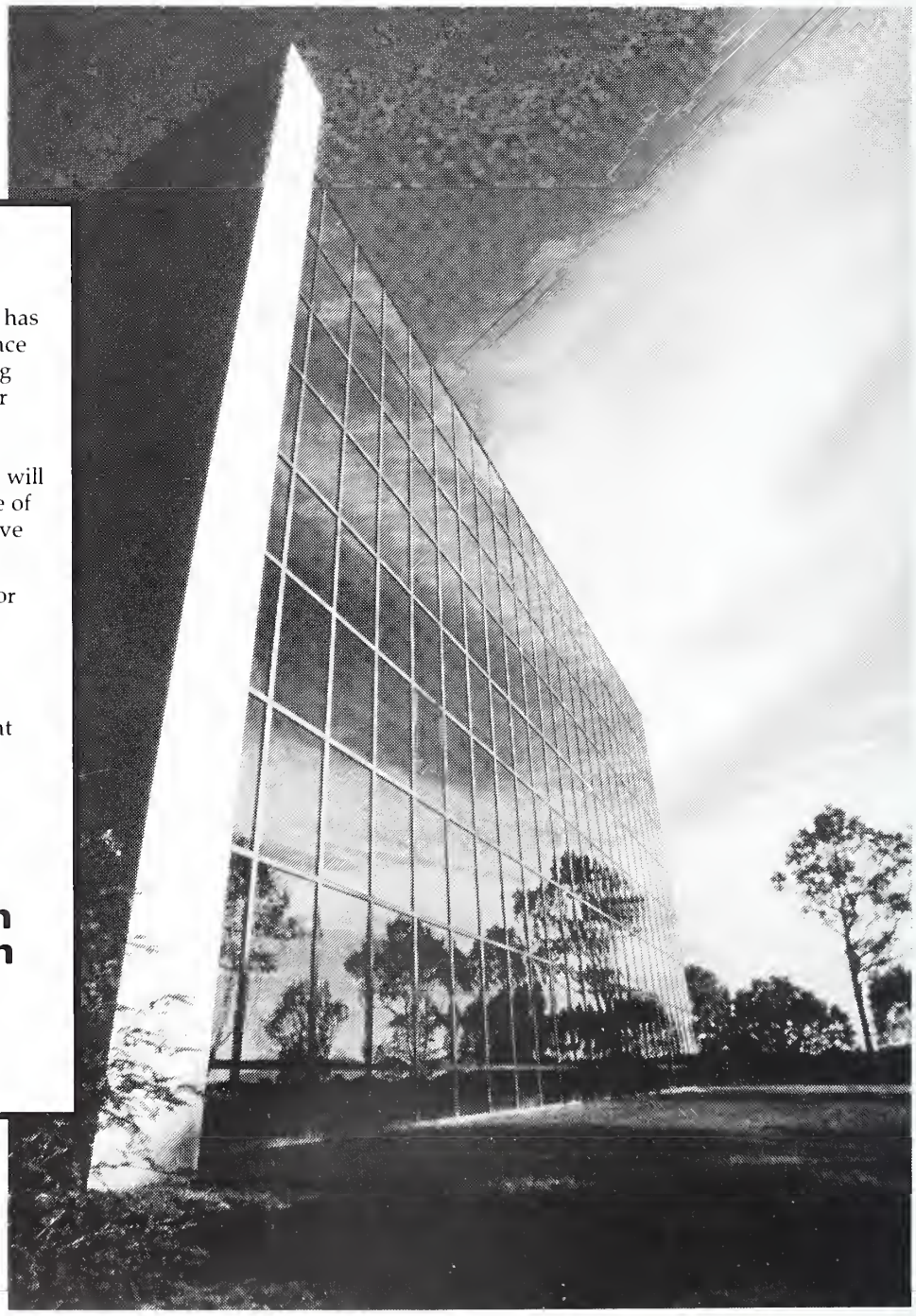

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CNA Unveils Third Generation Seminar

Charleston lawyer Don Sensabaugh (center) of Kay, Casto, Chaney, Love and Wise answers a question during CNA's Third Generation Seminar at the Ramada Inn in South Charleston on March 2. The other presenters for the symposium were George Burke of CNA (left) and Dr. Robert Patchell of Charleston (right).

CNA Insurance Companies premiered their "Third Generation" Seminar, the third segment of their Loss Control Program, at a special meeting at the Ramada Inn in South Charleston on Saturday, March 2.

This new seminar is for CNA insureds only and is devoted to understanding the legal parameters that are involved in a malpractice allegation; the court and judicial process as it relates to malpractice actions; techniques that may be employed to provide physicians with a degree of malpractice protection; and strategies that physicians may choose to employ (with the advice of legal counsel) to mount a successful malpractice defense if required.

Conducted by presenters trained in malpractice litigation, this symposium identifies the legal proceedings which occur after a plaintiff brings suit. It features a videotaped program which chronicles the progress of a hypothetical malpractice case, Marbury v. Madison, and symposium presenters conduct discussions and other activities to highlight the key points contained in the example case.

CNA designed the symposium to increase physicians' knowledge of the legal system as it applies to malpractice cases, so there would be less chance of them being involved in a case, as well as hopefully contributing a positive outcome if they are named in a suit. The assumption is that exposing physicians to the realities of the litigious environment will reduce their anxiety about the unknowns in the process, improve their performance before, during and after the suit, and increase the overall results of malpractice actions in favor of the defense.

In addition, the seminar's other primary goal is to illustrate behaviors in everyday practice — aside from the practice of medicine itself — that can trigger a lawsuit. Non-medical behaviors on the part of the doctor and employees can also have significant effects on the outcome of a suit, regardless of its legitimacy. For example, adequacy of the records, altered records, and the way the office staff relates to the patient all can affect a jury's decision.

Third generation seminars are scheduled throughout the state in 1991. For further information, contact the WVSMA office at 925-0342.

Cancer Program Planned for Low Income Women

The West Virginia Bureau of Public Health, Division of Maternal and Child Health, Women's Services, has made application to the Centers for Disease Control for funds to support breast and cervical cancer screenings for uninsured women in West Virginia.

The WVSMA endorses this program which would make clinical screening services available at 113 separate primary care centers and health departments in the state where comprehensive family planning medical care is currently being provided. These facilities had recognized a significant void in cancer prevention services for patients who were ineligible for family planning care.

The incidence of breast and cervical cancer in West Virginia and the lack of financial support for screenings, is a primary concern for the Office of Community Health Services. Initial funding was obtained in August 1990, for evaluating current resources for availability and barriers to care, as well as to establish a surveillance system.

The Breast and Cervical Cancer Screening Grant is expected to be awarded this spring and at that time clinical examinations will begin in the participating primary care centers and local health departments.

For more information, contact Helen Fisher, Director of Women Services, Bureau of Public Health, 1411 Virginia St. E., Charleston, WV 25301, 348-5388 or 1-800-642-8522.

VA Ophthalmologists to Meet in May

The Annual Meeting of the Virginia Society of Ophthalmology will be held May 10 and 11 at the Hyatt Regency in Reston, Va.

Contact Donna Scott, (804) 353-2721 for more information.

Shriners Schedule Children's Clinic

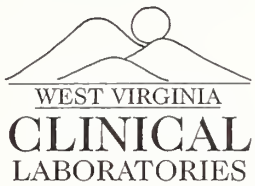
Beni Kedem Temple in conjunction with the Lexington Unit of the Shriners Hospitals for Crippled Children will hold a mini-clinic to examine and evaluate children for treatment at the Shriners Hospitals.

The clinic will be held on Saturday, May 11, between the hours of 9 a.m. and 4 p.m. at Beni Kedem Temple, 100 Quarrier Street in Charleston.

Children will be accepted for treatment of congenital orthopedic deformities, problems resulting from orthopedic injuries and diseases of the bones, joints and muscles. All children from infancy to 18 years of age are eligible for treatment, if in the opinion of the hospital staff, there is a reasonable possibility that treatment will benefit the child and that treatment at another facility would place a financial burden on the patient's family or guardian.

Referrals from area physicians are welcome. For additional information, contact Beni Kedem Temple at 343-9405.

WVSSMT Celebrates National Week



Members of the West Virginia State Society for Medical Technology (WVSSMT) and clinical laboratory professionals throughout the nation will be celebrating National Medical Laboratory Week from April 14-20.

This year's theme is "Working Together for Your Good Health," to emphasize the vital diagnostic role that clinical lab scientists have in ensuring quality health care for patients of all ages.

For more information about the WVSSMT, contact Nancy Endrizzi at 242-9871.

New WVSMA Committee Formed

WVSMA President Michael M. Stump, M.D., has created the Freedom of Medical Practice Committee whose goals are to originate and/or investigate, evaluate and analyze concepts and technical strategies and tactics to enable and encourage physicians to practice medicine freely, individually and responsibly.

Richard S. Kerr, M.D., of Morgantown, is the chairman of this new committee and the other members are James L. Bryant, M.D., of Clarksburg; Ronald E. Cordell, M.D., of Charleston; Robert P. Pulliam, M.D., of Beckley; and Tara C. Sharma, M.D., of Huntington.

ASIM Conference to Explore Health Trends, RBRVS

An update on the Health Care Financing Administration's proposed Resource - Based Relative Value Scale (RBRVS) implementation guidelines and a look into the future of U.S. health care will headline ASIM's 1991 Leadership Development Conference, May 9-11 in Minneapolis.

The conference, "Getting Fit For the Future," is aimed at current and future leaders in internal medicine in any setting.

Leonard Schaeffer, former Secretary of Health and Human Services and the current chairman of Blue Cross-Blue Shield of California, will offer his views on universal access to health care in America. Also, Robert McCord, executive director of the Congressional Institute for the Future (an organization that provides briefings and publications on future trends for members of Congress), will address the major trends affecting health care today. In addition, HFCA representatives and the Physician Payment Review Commission will provide an update on the RBRVS.

Workshops will train leaders to play an active role in the legislative arena and topics covered will include conflict resolution, effective public speaking and media relations.

For more details, contact Lisa Derby at (202) 682-8615.

Five Psychiatrists Appointed to Compensation Committee

Drs. Ramesh Shah, Ralph Smith Jr., Martin Comer, Khalid Hasan and Charles Weise are now serving as members of the West Virginia Workers' Compensation Fund Psychiatric Standards Committee.

The committee's purpose is to provide a basis for an objective psychiatric evaluation of claimants, to set standards for the examination and impairment rating process, and to make recommendations for the treatment and rehabilitation of claimants having psychiatric disorders.

AMA Plans 17th HMSS Conference

This year's AMA Hospital Medical Staff Section 17th Assembly Meeting is scheduled for June 20-24 at the Chicago Marriott Hotel.

Highlights will include:

- An educational program on the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and Practice Parameters;
- A presentation by the AMA-HMSS Governing Council of reports on medical staff issues;
- An information exchange on PRO and Managed Care Review;
- AMA-HMSS Governing Council elections.

For information contact AMA at (312) 464-4754 or 464-4761.

Moments in America

Every 35 seconds an infant is born into poverty.

Every 2 minutes an infant is born to a mother who received late or no prenatal care.

Every 2 minutes an infant is born at low birthweight (less than 5 pounds, 8 ounces)

Every 11 minutes an infant is born at very low birthweight (less than 3 pounds, 8 ounces)

Every 14 minutes an infant dies in the first year of life.

Every 31 seconds an infant is born to an unmarried mother.

Every 55 seconds an infant is born to a mother who is not a high school graduate.

Every 21 seconds a 15-19-year-old woman becomes sexually active for the first time.

Every 32 seconds a 15-19-year-old woman becomes pregnant.

Every 64 seconds an infant is born to a teenage mother.

Every 5 minutes an infant is born to a teenage mother who already had a child.

Every 74 seconds a 15-19-year-old woman has an abortion.

Every 14 hours a child younger than 5 is murdered.

Every 5 hours a 15-19-year-old is murdered.

Every 2 hours a 20-24-year-old is murdered.

Every 2 seconds of the school day a public school student is suspended.

Every 4 seconds of the school day a public school student is corporally punished.

Every 10 seconds of the school day a student drops out of school.

Reprinted from The State of America's Children 1991, the annual report of the Children's Defense Fund in Washington, D.C.

AAO Criticizes New Federal Cataract Surgery Plan

A federal government plan to solicit cut-rate opthalmologist services will restrict access to care, endanger the quality of patient care and result in high-volume "cataract mills," George W. Weinstein, M.D., president of the American Academy of Opthalmology (AAO) has charged.

"The public should be outraged that the federal government would appear to put its seal of approval on cataract mills," Dr. Weinstein said.

A three-state test of so-called Preferred Provider Organizations has been announced for New York, Ohio, and Texas by the Health Care Financing Adminstration. Under the plan, opthalmologists at test sites in these three states would be solicited to offer their services to Medicare patients at lower fees as "preferred providers."

The AAO states that the danger in this plan is a temptation to shortcut professional medical pre- and post-operative care in order to produce the volume of surgery needed to sustain the operation.

"Cataract surgery is now largely a community-based outpatient surgical procedure with an extremely high success rate, at a relatively low cost to the patient and the Medicare program," Dr. Weinstein said. "Cataract-surgery fees, which have been reduced in recent years, are expected to be further decreased by at least 19 percent under the new Medicare physician payment reform, due to go into effect in January 1992, according to estimates by HCFA and other government agencies. Therefore, we see no reason to create a program which will allow government-financed inducements to patients and providers in order to find a high-enough volume of surgical cases to pass through the government cataract mills," he added.

The AAO is seeking Congressional sanctions against the program, and urges opthalmologists in the three test states, as well as their colleagues across the country to join in resisting implementation of this cataract PPO project.

Ohio State Offers Satellite CME Programs

Ohio State University's Center for Continuing Medical Education is expanding its communications operation by launching a new satellite television network aimed at physicians in this country and southern Canada.

Ohio Medical Education Network Television (OMEN-TV) will broadcast its first program on May 8, the first of six different presentations in the network's "Clinical Case Conference Series." The CME center is seeking OMEN-TV subscribers by contacting hospitals and other medical institutions with an interest in providing continuing medical education for its physicians through telecommunications.

The CME center is primarily seeking subscribing medical institutions within a 150-mile radius of Columbus, but since satellite technology makes it possible for most points of the United States and Southern Canada to receive a satellite signal simultaneously, any medical institution in those areas with a receiving "dish" will be welcome to subscribe to the network. The CME center will assist institutions in obtaining the equipment needed to receive the programs.

The 45-minute education programs will be followed by a 15-minute interactive segment in which viewers may call in questions directly to the experts over a toll-free phone line. The CME center will not only use OMEN-TV for live interactive programming, but will allow subscribing institutions to record the programs on videotape so other physicians can view the programs within their schedules.

Participating physicians are eligible to receive one credit hour per program in Category I of the Physicians Recognition Award of the American Medical Association. Ohio State has submitted the programs for consideration of prescribed hours for family physicians.

The first program May 8 will focus on repetitive motion trauma such as carpal-tunnel syndrome and tennis elbow. Other scheduled dates and programs are May 15, "Sudden Death and Exercise;" May 22, "Osteoporosis in Men and Women;" June 5, "Bone Marrow Transplantation: Is It Cancer's Final Cure?;" June 12, "Hypertension: Recent Advances in Diagnosis and Management;" and June 19, "Prenatal Diagnosis: Screening, Management and Treatment Implication."

Wilderness Seminar Combines CME, Whitewater Rafting

HealthNet and the Department of Emergency Medicine at Charleston Area Medical Center are sponsoring the Wilderness Medicine Seminar, June 1 and 2 with CME activities at the Holiday Inn-Charleston House and on the New River.

This seminar is intended to present recent advances, experiences, and problems in acute care. There will be presentations on topics such as the care of animal bits and current trends in the prevention of rabies; treatment and prevention of lightening injuries; and the care of venomous snake bites, skin illnesses and other outdoor recreational injuries. In addition to the lectures that will be offered on Saturday, June 1 at the Holiday Inn-Charleston House, there will be CME events the following day as part of a whitewater raft trip on the New River.

The program is acceptable for 11½ prescribed hours by the American Academy of Family Physicians and the AMA Physician Recognition Award. It is also approved by the American College of Emergency Physicians for 11½ hours of ACEP Category I credit and 11½ hours CAT D2 of the American Osteopathic Association.

HealthExpo, a recruitment fair, is being held in conjunction with the Wilderness Seminar and representatives from more than 40 hospital programs, residency programs and health care companies will be having exhibits.

For more details or to register, contact Dr. Seidler at CAMC's Department of Emergency Medicine, 348-9015.

Carolinas Medical Center Hosts Spring Symposium

Medical experts from across the country will gather at the Omni Hotel in Charlotte April 29 - May 3 to discuss some of the most newsworthy issues in the field of medicine during the Carolinas Medical Center Spring Symposium '91.

U.S. Surgeon General Antonia Novello and U.S. Secretary of Health and Human Services Louis Sullivan are among the nationally recognized authorities invited to attend. In addition, CBS News commentator Charles Kuralt will be the featured banquet speaker on May 1.

Symposium topics and presentations will revolve around nine medical disciplines, including emergency medicine, internal medicine, pediatrics, family practice, dentistry, orthopaedics, oncology for nurses and physicians, obstetrics and gynecology, and general surgery.

For more details, contact Scott White, Carolinas Medical Center, (704) 355-3141.

Laparoscopy Techniques Topic of Spring Meeting

International pioneers in laparoscopic surgery will unite to share and teach their techniques during an "Advanced Laparoscopic Surgery" conference Monday, May 20 through Wednesday, May 22 in Indianapolis.

The conference will provide a "window into the future" of laparoscopic surgery, according to Maurice E. Arregui, M.D., of Indianapolis' St. Vincent Hospital and Health Care Center, which is hosting the event.

The three-day conference is endorsed by the Society of American Gastroentestinal Endoscopic Surgeons (SAGES) and the final day of the seminar will be broadcast via satellite to Europe, Asia and throughout the Americas.

For more information, call Beth Hartauer at (317) 871-3460.

Study Shows Parity of Eminase, tPA

Results of TEAM-3, the first head-to-head American trial of Eminase (APSAC, anistreplase) vs. tPA (Activase, alteplase) were reported in Atlanta on March 5 at the 40th Annual Scientific Session of the American College of Cardiology (ACC).

The 28-center study which was directed by Jeffrey L. Anderson, M.D., professor of medicine at the University of Utah, reinforces the findings of the larger Third International Study of Infarct Survival (ISIS-3) study also reported at ACC - there is basic parity among thrombolytic agents.

"While ISIS-3 was primarily a 35-day mortality study that compared streptokinase, APSAC and tPA (duteplase), TEAM-3 was a direct 30-day comparison of key morbidity endpoints between APSAC and tPA (alteplase)," Dr. Anderson explained. "Unlike ISIS-3, where patients received subcutaneous heparin, all TEAM-3 patients received heparin by IV drip, the preferred method of administration in America," he added.

TEAM-3 was a double-blind study that randomized 161 myocardial infarction patients to Eminase and 164 patients to tPA. All patients were under 75 years of age; none had been treated for earlier myocardial infarctions with either Eminase or streptokinase.

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County Societies

McDowell

At the February meeting, W. Merva, M.D., Princeton neurologist, gave a lecture on the "Diagnosis and Treatment of Parkinson's Disease."

Under new business, members tabled a request for funds for Project Graduation 1991 and Dr. Herland gave a report on the WVSMA Council meeting held on January 27. Dr. Herland discussed plans to meet with Welch Emergency Hospital administration and other individuals interested in creating a local health center and he also encouraged members to become active in medical education programs.

Sandoz Pharmaceuticals sponsored the dinner and meeting.

The society's next meeting was held on March 13 and videotape #4 in the series of "Issues in the Management of Hypercholestrolemia" was presented with a CME workbook.

Members unanimously voted to give $150 to the three area high schools for Project Graduation 1991 and talked about WVSMA and AMA dues and the benefits of membership. An application from Piayon Emmanuel Kobbah, M.D., was also accepted.

Monongalia

Dr. Emery Sasses, dean of the WVU School of Journalism, spoke on medical goodwill in the local community at the February meeting.

Dr. Kerr gave a report on the recent WVSMA Council meeting and Drs. Robert Nugent and David Lynch were presented for retired status. The names of Drs. Vincente Cortes, J. Patel and R. Vaglienti were put into reading as possible new members. In addition, Dr. Sebert, chairman of the Ad Hoc Committee on Communications, outlined the committee's recommendations on reaching all members regarding significant legislation.

At their next meeting on March 5, Rodney Kovach, M.D., spoke on Mohs Micrographic surgery.

Four new candidates were then submitted for membership via first reading: Drs. Gibson, Vance, Helsley and Mann; and Drs. Cortes and Patel were submitted for membership via second reading. In addition, Drs. Glover, Kerr and Jones addressed legislative issues.

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Continuing Education

Listed on this page are some of the upcoming continuing education programs which will be held throughout the state.

The programs this month were compiled by the following individuals: Suzanne Nowell, WVU outreach coordinator of CME; Cynthia Kemp, WVU conference planner; David Bailey, MU director of CME; Robin Rector, coordinator of CME for Charleston Area Medical Center; Arlene S. Feder, M.D., coordinator of Medical Grand Rounds for Ohio Valley Medical Center; and Je H. Kim, M.D., secretary of the Tug Valley Medical Association.

These programs are tentative and subject to change. Further details about these CME activities may be obtained by calling Nowell and Kemp at 293-3937; Bailey at 696-7018; Rector at 348-9580; Feder at 234-1835; and Kim at 235-7549. Other national and state meetings are listed in the Medical Meetings Section of the *Journal*.

This schedule is presented as a convenience for physicians. If you would like to have the continuing education programs offered by your institution or association published in the *Journal*, please contact Nancy Hill, managing editor, at 925-0342.

CAMC/WVU Health Sciences Center - Charleston

April 22 - "Pediatric Emergencies," Women and Children's Hospital Boardroom, Teleconference, 12:30 p.m.

April 22 - "AHA/APP Neonatal Resuscitation Course," Women and Children's Hospital, Seminar/ Workshop, 8 a.m.

May 2 - "Pediatric Advanced Life Support," Women and Children's Hospital, Seminar/Workshop, 8 a.m.

May 3 - "18th Annual Newborn Day," Women and Children's Hospital, Seminar/ Workshop, 8 a.m.

May 8 - "Swallowing Disorders," General Division Room 420, Teleconference, 12:30 p.m.

May 11 - "Functional Endoscopic Sinus Surgery Course for the Practitioner," Sponsored by WVU Department of Otolaryngology/Head and Neck Surgery and the WV Academy of Otolaryngology/ Head and Neck Surgery

WVU Health Sciences Center - Morgantown

May 17 - 4th Annual Symposium of WV Network of Ethics Committees, "Making Difficult Health Care Decisions: The Role of Ethics Committees"

MU School of Medicine - Huntington

April 8 - Pre-Research Day "New Approaches to Development of New or More Effective Viral Vaccines," Robert M. Chanock, M.D., NIH, Bethesda, MD., MU Student Center, Shawkey Room, 7 p.m.

April 9 - Fourth Annual Research Day, Holiday Inn-Gateway, 7 a.m. - (registration)

Ohio Valley Medical Center - Wheeling

April 10 - "Spondyloarthropathies," Dipti Shah, M.D.

April 24 - "Lipids and the Heart: A Cardiologist's View," Francis Oliver, M.D.

HCA Raleigh General Hospital - Beckley

April 19 - "Perinatal Care," Roy H. Petrie, M.D., Sc.D., 9 a.m.

Tug Valley Medical Association - Williamson

April 10 - "Hypertension and Challenge of Controlling Coronary Artery Disease," Julia Espiritu, M.D., Western Sizzlin Steak House, Goody, KY, 6:30 p.m.

CME Outreach Programs

Key to Sponsors

★ WVU Health Sciences Center, Morgantown

☐ CAMC (•)/WVU Health Sciences Center-Charleston (△)

(Check locally for additional information)

Fairmont ★ Fairmont Clinic, April 17, 1 p.m., "Geriatrics," David Z. Morgan, M.D.

New Martinsville ★ Wetzel County Hospital, April 11, 11:30 a.m., "Angioplasty of Coronary Vessels--Will it Replace Bypass Surgery?" Abnash Jain, M.D.

Parkersburg ★ Camden Clark Memorial Hospital

April 10, 7 a.m., "Lyme Disease in Children," Norman Ferrari, M.D.

April 17, 7:30 a.m., "Diabetes and Pregnancy," Elliott Chideckle, M.D.

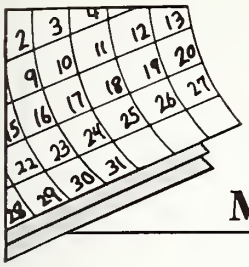
April 24, 7 a.m., "Difficult Diagnostic Problems in Pediatrics," TBA

White Sulphur Springs ☐ Greenbrier Clinic, April 16, 4 p.m., "Current Management of Asthma," Lu Lapp, M.D.

Waynesburg, Pa. ★ Greene County Memorial Hospital, April 23, 7 p.m., "Oncologic Emergencies," Peter Raich, M.D.

Whitesville ☐ Raleigh-Boone Medical Center, April 24, 11 a.m., TBA

Williamson ☐ Williamson Memorial Hospital, April 10, 6:30 p.m., TBA, Julian Espiritu, M.D.



Medical Meetings

April

19-20—Spring Meeting WV Chapter of the American Academy of Pediatrics: Issues for the Practitioner, Wheeling.

19-21—Focus on the Athletic Patient, Southern Medical Association, Hilton Head, S.C.

19-21—Advances in Surgical Techniques and Technologies, Southern Medical Association.

20—Management of Common Bile Stones and Biliary Structures: A Multidisciplinary Approach, Georgetown University Medical Center, Washington, D.C.

21-23—8th National Conference on Prescription Medicine Information: Managing Diversity in Medicine Communication, Washington, D.C.

21-24—Introductory Perimetry Course, Ohio State University, Columbus.

26-28—Diagnostic Dilemmas in Cardiology, Southern Medical Association, Myrtle Beach, S.C.

29-May 1—Carolinas Medical Center Spring Symposium 91, Charlotte, N.C.

May

3-5—Diagnostic Dilemmas in Neurology and Psychiatry, Southern Medical Association, Point Clear, AL.

4—Second Annual Clinical Lipid Symposium: Clinical Management and Regression of Atherosclerosis, Ohio State University, Columbus.

8-10—Industrial Audiometry and Conservation of Hearing, Ohio State University, Columbus.

8-11—193rd Annual Meeting Medical and Chirurgical Faculty of Maryland, American Medicine Today: Perspectives from Maryland, University of Maryland, College Park, MD.

9-11—American Society of Internal Medicine's 1991 Leadership Development Conference, Minneapolis.

10-11—Annual Meeting of the Virginia Society of Ophthalmology, Reston, VA.

10-11—Emergency Medicine: The Cutting Edge, Georgetown University Medical Center, Washington, D.C.

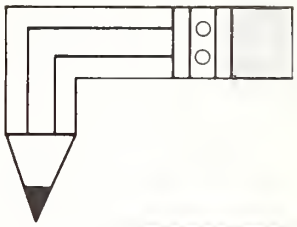
16-19—Focus on the Female Patient, Southern Medical Association, Panama City, FL.

19-22—14th Annual National Rural Health Association Conference, Seattle.

For More Information . . .

Contact The Journal for additional information about most of the above meetings. Call (304) 925-0342.

Poetry Corner



The Good Life

Gently the days follow each other.
One coming into view
As the preceeding one disappears from sight.
So smoothly they come, so easily they go
each taking with it an allotment of memories.
Unimportant memories, important memories
All tailored in some fashion to fit the days
they accompany.

Thus goes my life slipping away
Smoothly mind you --- no regrets.
no sense of loss.
The opiate of summers warm days and blue skies
Soft winds, romantic thoughts.
Leads me, uncomplaining to the next day
Wherein if I am lucky there will be no problems.

Is time thus meant to lead us - aye to shove us
Into the quicksand of a do-nothing life?
Is there no excitement in living?

Tell me that it will get better
That spring's green growing will return
That fall's flashing colors will shake us
Even winter's sterile white cold is better than
The smothering of Morpheus

J. Paul Aliff, M.D.

Appreciation

Deployed in blowing desert sand,
Large numbers of the very best
Young men and women of our land
Are serving there at our behest.

They need support from all of us;
The best and most that we can send,
They need to know they have our trust;
To know that we will never bend.

We owe them this at very least
For the courage they display
While serving in the Middle East,
And living daily in harms way.

But as soon as it is finished there,
We need to bring them home once more;
To let them have an ample share
Of the freedoms they are fighting for.

And we need to give them all a hand
For the sacrifices they have made
While serving in a foreign land;
For support of country they've displayed.

E. Leon Linger, M.D.

Please address your submissions for Poetry Corner to: Stephen D. Ward, M.D., Editor, West Virginia Medical Journal, Box 4106, Charleston, WV 25364.

Your CPA: A Business Investment

Question: Your company's not quite doing as well as you think it should, but you're not sure what to do about it. What you should do is:

- ☐ a. Bury your head in the sand.
- ☐ b. Worry about it tomorrow.
- ☐ c. Keep doing what you've done.
- ☐ d. Forget it - go on vacation.
- ☑ e. Call a CPA!

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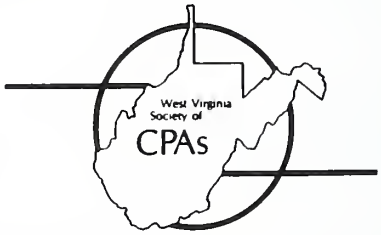

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WEST VIRGINIA UNIVERSITY HEALTH SCIENCES CENTER

Compiled from material furnished by the West Virginia University Health Sciences Center News Service, Morgantown.

Ethicists Differ on Liver Transplants for Alcoholics

The shortage of human livers available for transplantation means that some patients will die waiting for a suitable organ, according to Dr. Alvin Moss of WVU's Center for Health Ethics and Law.

In an article published in the March 13 issue of the *Journal* of the American Medical Association, Dr. Moss, along with co-author Dr. Mark Siegler of the University of Chicago, says people with liver damage caused by failure to seek treatment for long-term alcohol abuse should be lower on the priority list for transplants than others with liver disease.

Drs. Moss and Siegler point out that donor livers are in extremely short supply. Fewer than 2,000 liver transplants were performed in 1989 and tens of thousands of Americans died of liver failure that year.

"In view of the dire, absolute scarcity of donor livers, it is fair to hold people responsible for their choices, including decisions to refuse alcoholism treatment, and to allocate organs on that basis," Drs. Moss and Siegler state in the article.

In addition, Drs. Moss and Siegler say that providing liver transplants on a first-come, first-served basis, with alcohol-related cases placed on the same basis as those whose liver disease is not linked to behavioral factors, will erode public support for this life-serving technology.

But their views are not universal among medical ethicists. Carl Cohen, Ph.D., and Martin Benjamin, Ph.D., both of the Transplant and Health Policy Center in Ann Arbor, Mich., challenge their position in the same issue of the *Journal*.

Drs. Cohen and Benjamin say alcoholism is a bar to transplant surgery only if doctors "assume that qualification for a new organ requires some level of moral virtue or is canceled by some level of moral vice."

"We are not suggesting that patients with alcohol-related end-stage liver disease (ARESLD) should never receive transplants," Dr. Moss said. "Rather, we propose that a priority ranking be established for the use of this dire, absolutely scarce societal resource, and that patients with ARESLD be lower on the list than others."

New Clinic Treats Work-Related Lung Illnesses

A new clinic at the WVU Health Sciences Center provides diagnosis and treatment for people suffering from lung diseases resulting from exposure to dust or chemicals in the workplace.

The Occupational Lung Clinic was established early this year as part of a program funded by the National Institute for Occupational Safety and Health (NIOSH) to develop a center for research, treatment and medical training related to workplace-related lung disease.

In West Virginia and surrounding states, occupational lung diseases are most commonly associated with the coal, chemical and glass industries, Dr. Daniel E. Banks, director of the clinic said.

"Coal and silica dust, airborne asbestos, and chemicals are the agents most typically associated with lung problems," Dr. Banks explained. "WVU doctors often treat patients with workplace-induced asthma, a condition which can be developed after exposure to isocyanates, industrial paints, electrical soldering or gases."

In addition to Dr. Banks, Drs. N. LeRoy Lapp, Marvin R. Balaan, Henry Abrons and Edwin Morgan as well as NIOSH physicians will treat patients at the clinic. The clinic also will perform OSHA-mandated lung disease screenings for people in hazardous occupations.

Persons who think they may be suffering from occupational lung disease should consult a physician. Physician referrals to the clinic at WVU can be made by calling 598-4855.

In addition to treating patients, the clinic will train practicing community physicians in techniques for assessing the health of workers suspected of having occupational lung disease. Physicians who would like to participate in this training may call Dr. Banks at 293-4661.

WVU Dedicates Rector Lectureship

WVU has dedicated a visiting lectureship to honor Stephen C. Rector, M.D., the former director of emergency medicine for the WVU Health Sciences Center.

The lectureship will bring distinguished emergency physicians to WVU to provide instruction and clinical training to medical and nursing students, staff, and emergency health care providers from throughout the state. It is intended to be an essential element of the proposed emergency medicine residency program which Dr. Rector has been working to establish at Ruby Memorial Hospital.

Dr. Rector, who was present for the ceremony, was diagnosed in late 1990 with an incurable brain tumor, and is no longer seeing patients. An associate professor in the WVU Department of Surgery, Dr. Rector addressed his friends and colleagues, thanking them for the recognition. "I'm overwhelmed by your friendship and generosity," he said.

The WVU School of Medicine and WVU Hospitals set a joint goal of $100,000 to endow the lectureship program and more than $90,000 in gifts and pledges has already been raised.

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MU School Of Medicine News

MARSHALL UNIVERSITY

Compiled from material furnished by the Office of University Relations, Marshall University.

Aulick Researching Immune System of Burn Victims

A Marshall University School of Medicine researcher is on the trail of a molecule in the blood that may someday improve burn victims' chances of survival.

Dr. Louis H. Aulick, professor of physiology, is working under a $34,000 grant from the U.S. Army Medical Research and Development Command to locate and analyze a molecule believed responsible for suppressing the immune systems of burn victims.

According to Dr. Aulick, the immune systems of all burn patients fail to go into action, and it is infection rather than burns that often leads to death. By studying the blood of burned laboratory rats, Dr. Aulick has already isolated what he believes is the inhibitor to interleukin-1, a powerful substance critically important in the body's response to injury and disease.

"Interleukin-1 serves to actuate almost the entire immune system," Dr. Aulick said. "If anything blocks interleukin-1, the immune system is depressed."

The target of the pilot study is to determine what the inhibitor is and how it acts. Dr. Aulick plans to seek an additional Army grant this spring to accomplish the next step, which is to get the inhibitor in a pure enough state so that it can be synthesized in the laboratory.

Dr. Aulick's findings may have research implications beyond the burn response itself. An inhibitor with characteristics similar to the one under study in Dr. Aulick's lab is known to block interleukin-1 in AIDS patients and he has found some of the inhibitor in the blood of control animals.

"The inhibitor may be part of the normal control process of interleukin-1, and we may be seeing a normal control mechanism much accentuated in burns," Dr. Aulick said. "We are at the frontier of knowledge at the molecular level."

Purification and synthesis of the inhibitor are crucial for the further study needed before any clinical applications of Dr. Aulick's work are possible.

"If we can produce pure inhibitor, we can then make an antibody to counteract it," Dr. Aulick explained. "The next step would be to administer the antibody to burned rats, then watch for fever and other signs that the inhibitor was no longer suppressing the immune system. Clinical trials with humans would come later," he added.

Dr. Aulick came to the MU School of Medicine in 1984 following nearly 10 years as a researcher at the Brooke Army Medical Center in Texas, where burn victims from all over the country are treated. The Army has continued to support Dr. Aulick's research at Marshall, awarding him $123,000 in 1987 to study the metabolic rates of burn victims.

New Family Nurse Practitioner Program Underway

Graduate students in Marshall University's new program to educate family nurse practitioners see themselves as part of the solution to the problem of lack of access to cost-effective health care in many areas of the state.

"We are always hearing about the shortage of health care providers," Donna Weber, an RN currently working at Cabell Huntington Hospital said. "The answer is in our classroom."

Weber is among the first 16 students to enroll in Marshall's master of science in nursing program. Like others in her program, Weber expects to put her advanced level nursing skills to work in an outpatient clinic setting.

Kathy Willis, RN, a Lincoln County school nurse also enrolled in Marshall's graduate nursing program, plans to take her nurse practitioner skills right back home. Her goal is to provide more comprehensive school health services, involving the whole family in students' health care. Marshall is especially looking for nurses like Willis who plan to take their expanded skills and return to rural areas to practice.

Completion of the Marshall program qualifies graduates to manage such illnesses as diabetes and high blood pressure; treat conditions such as earaches and sore throats; give physical examinations and immunizations; manage uncomplicated pregnancies; and more, according to Dr. Giovanna B. Morton, graduate program director and professor in Marshall's School of Nursing.

"Family nurse practitioners are specially educated to serve the day-to-day health care needs of all age groups, from infants through the elderly," Dr. Morton said. "Most often, family nurse practitioners work side by side with physicians in a primary care setting, collaborating on treatment plans and referring cases to the physician's care when necessary. Our program focuses on leadership education, on the knowledge and skill needed to function independently as well as collaboratively with other health care providers," he added.

Nurses in the program have ample opportunity to practice their advance-level skills in the field. Each of the first three semesters, the nurses spend part of their program clinical training in a rural setting and their final semester consists of a supervised internship, which may be in one or more clinical settings, provided they see patients of every age. They may also arrange an internship in their home community with adequate supervision.

This MU program is the first in the state specifically designed to educate family nurse practitioners, and it takes two years for full-time students and three to four years for part-time students.

More information is available from the School of Nursing at 696-2636.

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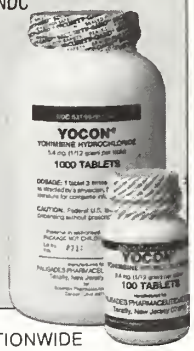

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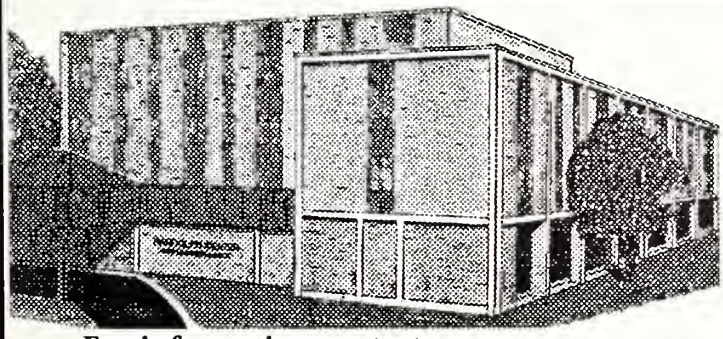

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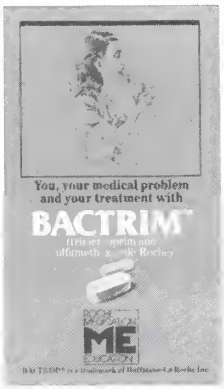

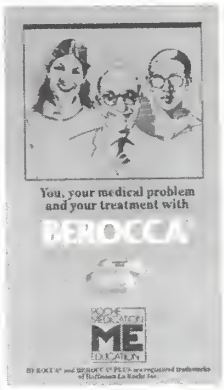

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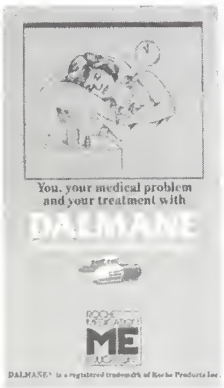

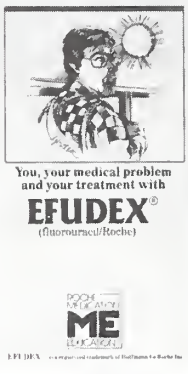

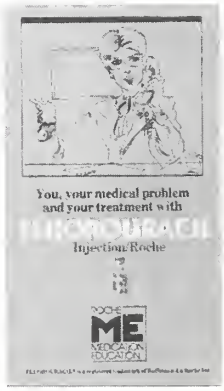

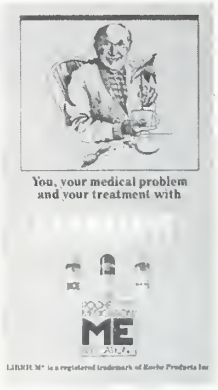

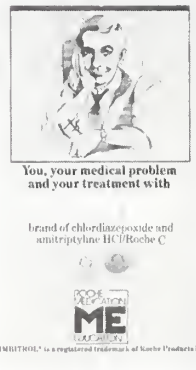

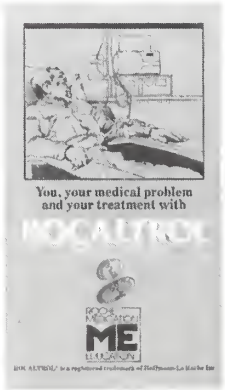

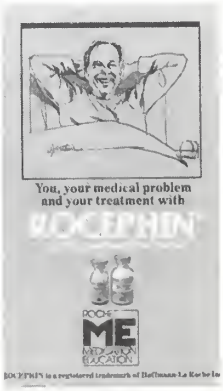

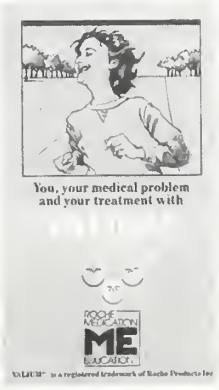

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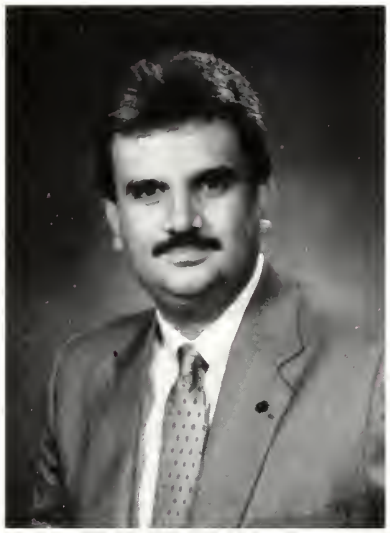

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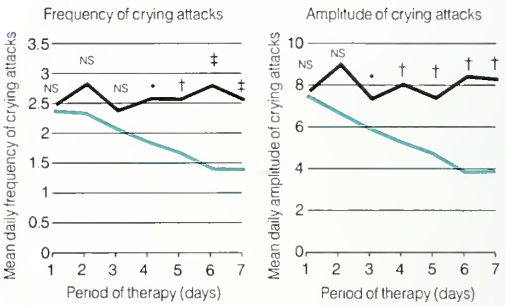

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Front Cover

A young white-tail deer at Canaan Valley State Park. Photo courtesy *Stephen J. Shaluta Jr., West Virginia Department of Commerce.*

Update on Blue Cross & Blue Shield Liquidation

STEVEN L. THOMAS
Kay, Casto, Chaney, Love & Wise, Charleston

The West Virginia State Medical Association has been actively participating in the proceedings involved in the liquidation of Blue Cross & Blue Shield of West Virginia (BC/BS of WV). This article will describe the current state of affairs in the liquidation process.

How To File Claims

In April, materials should have been mailed to all creditors of BC/BS of WV to enable the filing of Proofs of Claims. The deadline for filing Proofs of Claims is July 8. In many instances, the materials accompanying the Proof of Claim forms will include a claims listing, which indicates the amount of the claim for a given provider according to the books and records of BC/BS of WV. A provider should review the claims listing if it accompanies the claims materials, to determine if he or she agrees with the amount of the claim as listed. If the provider agrees with the claim as listed, then all he or she needs to do is fill out the Proof of Claim form, sign and return it.

If the provider does not agree with the amount listed for the claim, then he or she must attach the documentation described in the Proof of Claim instructions. Pursuant to the instructions accompanying the form, all providers must then list they are Type 2 claimants, with Class III claims.

Ordinarily, providers will not be "secured claimants." A secured claimant is one who holds collateral to secure payment of his or her claim. Also, providers ordinarily will not be in a position to assert an offset in connection with their claim. A right to offset arises where the provider owes money to BC/BS of WV, and concurrently has a claim against BC/BS of WV. Any provider who owes money to BC/BS of WV should elect to assert an offset. The effect of this is to reduce (or eliminate) the debt the provider owes to BC/BS of WV by netting it against his or her claim in the liquidation. By asserting an offset, the provider achieves a dollar for dollar reduction in the amount owed to BC/BS of WV. If the provider does not elect to assert an offset, the liquidator of BC/BS of WV will seek to collect the debt owed by the provider to the liquidation estate. The provider will have to pay this debt in full, but will receive only a partial payment on his or her claim. Accordingly, the dollar for dollar offset is lost.

Non-participating providers will not receive a claim listing. The reason for this is that, in this instance, the records of BC/BS of WV reflect the debt owed to the subscriber, instead of to the provider. If a non-participating provider files a Proof of Claim which duplicates a claim filed by a subscriber, the liquidator will most likely disallow the claim of the provider and pay the claim of the subscriber.

Once again the deadline for filing Proofs of Claims is July 8. If, for some reason, a provider is unsure of the amount of his or her claim, the provider should nonetheless file a Proof of Claim before the stated deadline, and indicate that the claim is unliquidated.

A special problem is created, from the perspective of the liquidator, by "participating providers" (that is, those providers who had a "participating provider agreement" with BC/BS of WV), who bill their patients for amounts which should have been paid by BC/BS of WV (this does not include co-payments and deductibles). The liquidator has stated that he may attempt to seek an injunction against providers to prevent them from billing their patients for such amounts. WVSMA has stated its position to the liquidator that such an injunction would be legally questionable and practically unenforceable.

Nonetheless, physicians should recognize the practical problem created by billing their patients for amounts which should have been paid by BC/BS of WV. This practice makes the task of identifying the proper claimants in the liquidation problematic. A provider who bills his patient for such amounts and files a Proof of Claim in the liquidation for the full amount of his or her claim runs the risk of being accused of presenting a false claim in the liquidation. The reason for this is that, to the extent a physician recovers from his patient, this reduces the amount of his claim in the liquidation. By the same token, to the extent a patient pays a physician, the patient (as subscriber) then has a claim in the BC/BS of WV liquidation. Without special steps to notify the liquidator of these facts, the task of identifying the proper claimant in the liquidation becomes almost impossible.

For this reason, the WVSMA recommended to the liquidator that, as part of the Proof of Claim process, providers be notified that they have the option of either:

(a) filing a Proof of Claim in the liquidation and not billing their patients for the duration of the liquidation; or

(b) notifying the liquidator that such provider is not filing a Proof of Claim in the liquidation, but instead is electing to bill his patient(s) for all amounts owing, and thus his patient(s) are the proper claimants in the liquidation.

The liquidator rejected this proposal.

Nonetheless, the WVSMA recommends that all physicians follow the practice outlined in the preceding paragraph. That is, a physician should decide whether he or she wants to file a Proof of Claim and attempt to collect through the liquidation process, prior to resorting to billing his or her patients. In the alternative, the physician would elect not to file a Proof of Claim, and proceed to bill his or her patients. The physician would then immediately notify the liquidator of this election and the identity of the patient(s) holding the claim(s). This will enable the liquidator to timely perform his duty of identifying proper claimants for purposes of liquidating the assets of BC/BS of WV. To the extent a physician has already billed his or her patients and wishes to file a Proof of Claim, the physician should cease active attempts to collect such bills and file a claim in the liquidation, netting any amounts received from patients, and concurrently advising the liquidator of the identity of any patients who have paid a portion of their bill. Remember, this discussion only applies to participating providers.

Due to considerations detailed in the next section, the author recommends that physicians consider deferring collection actions against their patients during the pendency of the liquidation.

Control of Litigation

The WVSMA filed a motion to appoint a Creditors' Committee in the BC/BS of WV liquidation. The main reason for the filing of this motion is the concern that the Insurance Commissioner Hanley Clark may bear a portion of the responsibility for the losses suffered by creditors of BC/BS of WV. The insurance commissioner has recognized that, at a minimum, an appearance of a conflict of interest would exist if the insurance commissioner were to control the filing of law suits given the stated concern. As a result, the insurance commissioner has filed a Motion to Approve Proposal for Control of Litigation, which the WVSMA has tenatively endorsed as an alternative to a Creditors' Committee.

Pursuant to the proposal for control of litigation, Hanley Clark, as well as his agents and employees, would be excluded from the decision-making process regarding who to sue and where, and upon what grounds and terms. Under the proposal, David Gates (the liquidator hired by the insurance commissioner) would consult with interested parties in order to make recommendations to the court regarding who should be sued for contributing to the insolvency of BC/BS of WV. Intervening parties would be given the right to comment upon or object to the recommendations of Mr. Gates, and/or submit recommendations to the court regarding who should be sued.

After receiving direction from the court, Mr. Gates would determine the logistics of filing suit, including in what courts suit should be brought, whether certain defendants should be sued within the same suit, and what law firms should be retained to represent the interests of the liquidation estate. Once suits are filed, to the extent that compromises or settlements would be proposed, such compromises or settlements would again be subject to court approval, with the opportunity for intervening parties to comment and object.

Presently, the parties which have intervened in the liquidation are as follows: West Virginia State Medical Association; West Virginia Hospital Association; City Hospital, Inc.; Monongalia General Hospital, Inc.; Teays Valley Health Services, Inc. d/b/a HCA Putnam General Hospital; HCA Raleigh General Hospital, Inc.; Herbert J. Thomas Memorial Hospital; United Hospital Center, Inc.; Blue Cross of Western Pennsylvania; Pennsylvania Blue Shield; and the International Union of United Mine Workers.

The intervening hospitals are among the group of plaintiff hospitals in the suit filed in Federal District Court against Blue Cross & Blue Shield Association (BCBSA) and Blue Cross and Blue Shield Mutual of Ohio (the "Cleveland Blues"). These hospitals chose not to participate in the negotiations between the intervening parties and liquidator leading to the proposal for control of litigation. However, when the insurance commissioner filed his Motion to Approve Proposal for Control of Litigation, the hospitals appeared and objected. The hospitals now maintain that they should be allowed to proceed with their suit, but that they have no objection to other "similarly situated" creditors joining in their suit. WVSMA has taken the position that it does not oppose the suit brought by the hospitals, if such suit can be maintained on behalf of all creditors of BC/BS of WV, instead of solely for the benefit of those hospitals.

WVSMA has conferred with the plaintiff hospitals regarding the concern that a recovery by the hospitals would impair the ability of all other creditors to obtain a recovery against BCBSA. The hospitals have represented that they would not oppose an effort on behalf of the remaining creditors to intervene in their lawsuit on the condition that "such creditors be similarly situated providers who are not engaged in balanced (sic) billing." The WVSMA has told the hospitals its belief that no rational reason exists to exclude providers who bill their patients from the hospital's lawsuit. Further, that in the absence of such a rational reason, the WVSMA fears that the hospitals are imposing this condition solely, because of the practical impossibility of sorting out providers who bill their patients from everyone else. In other words, this condition could preclude timely intervention in the hospitals' suit on behalf of all remaining creditors.

For this reason, the author recommends that providers agree to defer continuing efforts to collect from their patients, pending resolution of the liquidation proceedings. Providers may want to notify their patients of this decision and inform them that the provider is not thereby agreeing to forgive the debt, but rather deferring action to collect.

Mountain State BC/BS

The Cleveland Blues have formally notified the state of West Virginia

that it no longer is willing to pay $7 million for the physical assets of BC/BS of WV, Inc. The stated reasons for this are numerous, including:

1. That Governor Caperton, President Burdette and Speaker Chambers failed to live up to their obligations under the "Project Agreement" to advance the legislative agenda of the Cleveland Blues;
2. That the suit brought by the 10 hospitals seeks diverstiture of Mountain State BC/BS from the Cleveland Blues, thereby casting a cloud on their ability to purchase the assets of BC/BS of WV;
3. That the physical assets of BC/BS WV are not worth $7 million;
4. That so-called "balance billing" by providers has "significantly deteriorated the Blue Cross Charleston book of business . . ."

As a result of this, the Cleveland Blues have stated they believe "that it is apparently not a prudent business judgment for Mountain State BC/BS to consider purchasing and/or owning and/or continuing to operate the Charleston facility."

Further, in a letter dated February 28, 1991, BCBSA informed Governor Caperton that "legislative and other developments in West Virginia, if not reversed or significantly amended, may ultimately lead to termination of the license and membership of Mountain State BC/BS, thereby leaving the people of West Virginia without a BC/BS plan." This letter goes on to state that "it is our present perception that several measures currently being considered by the West Virginia Legislature not only conflict with (the Project Agreement), but also may force us to terminate Mountain State's license to use our marks and membership in our organization." Finally, the letter states that "BCBSA has initiated the procedure for possible termination of Mountain State's license and membership in the event current trends continue."

No one knows whether the legislation passed in the most recent session will cause BCBSA to follow through with the course of action outlined in the February 28 letter. However, given this information, providers may wish to undertake planning to mitigate the consequences of a potential second insolvency proceeding. Many providers are parties to a so-called "Participating Provider Agreement." Such agreements typically give either party the right to cancel upon 30 days written notice. In addition, such agreements typically grant either party the right to terminate the agreement immediately upon a breach by the other side.

Arguably, these Participating Provider Agreements were breached by the insolvency of BC/BS of WV. Nonetheless, most providers apparently have not, to date, chosen to terminate their agreements for this arguable breach. Providers may wish to consider a procedure by which they can continue to receive payment directly from Mountain State BC/BS, without being parties to a Participating Provider Agreement. This should be achievable by the simple step of requiring patients/subscribers to execute an assignment of their right to benefits from Mountain State BC/BS. A provider would then send notification of this assignment to Mountain State BC/BS and it would then be obligated to make payment directly to the provider. By this means, the provider could achieve all the benefits of being a party to a "Participating Provider Agreement, and eliminate the primary argument raised against provider billings in the BC/BS of WV liquidation (that the patient is not the primary obligor on the debt for services rendered). In other words, a prohibition on the billing of patients for the obligations of a defunct BC/BS plan could be unsupportable.

It must be noted that most (if not all) subscriber agreements with the Mountain State BC/BS contain a clause prohibiting the subscriber from assigning the right to receive payment. However, this prohibition on assignment appears to be unenforceable, pursuant to Article 9 of the Uniform Commercial Code. Any provider should consult with an attorney to determine his or her specific legal options prior to implementing procedures outlined herein.

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THINGS I KNOW NOW that I Didn't Know or Appreciate Enough Before Serving in the Legislature . . .

Delegate Nancy Kessel, D—Kanawha

There are several important lessons to share after serving my first legislative term. The following points I consider critical to individual or group effectiveness in the legislative process:

1. Most major legislation does not originate during the session. Bills that pass have been discussed over the past months of public interim committee meetings and privately with affected groups. Although the legislation may not be in bill form until after the session begins, it likely has been conceptually agreed upon by most of the major players and has support of legislative leadership prior to the session.

   An example of this would be found in testimony offered at Health Care Task Force meetings in December 1990. My own personal notes revealed testimony which laid groundwork for the so-called "midwife" bill. This bill when introduced was poorly written, but my point is this, it wasn't a surprise and there should have been negotiation or an attempt to kill the bill early on — NOT AT THE FINAL HOUR.

2. Committee chairmen play critical roles. They have pledged support to legislative leadership and in most cases will only move bills which leadership has no objection to. And, to a great degree, their personal votes will be with leadership.

   If you have a committee chairman from your district, get to know him/her well. Time spent educating committee chairs about your positions will reap many benefits. They have the power to kill legislation by refusing to place bills on their agendas and, of course, to move bills you consider favorable. The death of the "midwife" bill can be credited to a couple of individual physicians who had existing relationships with senators in leadership positions. Professional lobbyists are most effective when backed up with a large contingency of interested, involved citizens. Legislators DO UNDERSTAND WHO ELECTS THEM and they will be responsive in most cases to constituency needs.

3. Bad bills or bills needing considerable "clean up" belong to someone. In other words, another group or individual loves that bill as much as you may hate it. Groups that are legislatively effective work at it year-round.

   The West Virginia Hospital Association was very effective with their legislation this year by spending the year laying groundwork with principal players. Blue Cross spent thousands of dollars, hired 11 lobbyists, had a massive letter-writing campaign and yet lost because they started without a firm base of support and had little or no credibility. I CANNOT EMPHASIZE ENOUGH THAT THE LEGISLATIVE EFFORT IS YEAR-ROUND.

   Bad bills should be kept off committee agendas using influence with leadership (assuming you believe the bill is so bad that there is no compromise position). If that cannot be done, kill or amend in subcommittee. The next step amending in full committee, but each step makes it more and more difficult to kill or amend. Bills gain support as they move through the committee process. Once a bill is reported to the full House or Senate, it is next to impossible to muster support for a defeat. It does happen, but rarely.

4. Don't create enemies! Keep emotion, personal put-downs, and hysterical arguments out of

the picture. A legislator who fights you on one piece of legislation may support you on the next.

In floor debate, legislators are held to a very strict set of rules to limit involvement of personality. Legislators are not allowed in formal debate to refer to fellow legislators by name, only by the district they represent (Gentlelady from Kanawha). Perhaps it sounds stiff and prudish, but it works by allowing us to move from one bill to another without putting personal grudges into the picture. This is something to remember when lobbying — be unemotional, factual, and kind because you may need to come back another day.

These four points are critical to legislative success. My experience this year was indeed stressful and frustrating at times, but I'm glad to have the chance to serve. I have said many times I admire the process. The problems with our government are in the people we elect to serve. We must be more involved in the political process of electing honest, hard-working individuals who will produce reasonable legislation to move the state in a reasonable direction.

Delegate Barbara Sims, R—Wood

The old adage that no one's life, liberty or pursuit of happiness is safe when the legislature is in session rang true to me during my first year of a two-year term as a delegate in the 70th Legislature of West Virginia. For example, fee increases were popular revenue-raising proposals in the House since tax payers seldom realize these hidden taxes. The House did pass a tax on sparkling water, termed the "Quibell Bill," however it did not pass the Senate.

I was one of the 26 Republicans in the House which, as I understand it, was a substantial increase from years past. The Republicans were able to gain some foothold in the House for the majority could no longer suspend the rules without the support of the minority. Suspension of the rules takes four-fifths vote or 80 of the 100 members. However, this power was seldom used because many times Republicans were split in their support of various issues.

There were a number of freshmen Democrats in the House who took the silent approach or remained quiet on issues important to them in hopes they would gain favor with leadership. However, at the close of the session, several of these freshmen expressed to me their frustration with either lack of action or action taken on important pieces of legislation. I predict next session or a special summer session, if called, will be quite different. Leadership will be fractured with allies choosing support for candidates in the 1992 gubernatorial election and with the turf battles in the redistricting from the four to three congressional districts. It is rumored that Speaker of the House Chuck Chambers, D-Cabell, is interested in a congressional seat.

As a member of the minority party, I experienced greater freedom in being able to ask questions, debate openly and vote my conscience without fear of reprisal. However, there are additional disadvantages to being a minority member. For example, the physical location of the minority members' offices which were in the east wing at the end of the hall, and the limited number of staff we were given to assist us in answering our mail.

The amount of mail was staggering and with the shortage of available staff, I soon gave up on attempts to answer mail from outside my district. I also chose not to respond to the surprising number of form letters that were poorly constructed or arrived without return addresses.

I served on the Judiciary, Health and Human Resources, and Industry and Labor Committees. I enjoyed the Judiciary Committee most and found a great deal of cooperation from the chairman, Delegate Jim Rowe, D-Greenbrier, and his staff. Under the chairmanship of Delegate Rowe, it was possible that some semblance of tort reform would be entertained in that committee. However, the most powerful committee is the Rules and the most powerful member of the House is the Speaker, and without the blessings of both, tort reform will never happen.

To illustrate the community of West Virginia and the relationships that we may not realize in the Legislature, I discovered that my husband, Gene, delivered the children of the chief counsel of Judiciary Mike Mowery.

It was revealing to witness the conduct of the Health and Human Resources Committee under the chairmanship of Delegate Pat White, D-Putnam. Delegate White and the

WVSMA have been at odds in the past over key health-related legislation, in particular the Omnibus Health Care Act of 1989. The staff assigned to this committee must have all graduated from the same school because they carried with them a school of thought on systems of health care similar to the Canadian style of health care delivery.

At times, I felt that the rules of the House floor were ignored and that issues were rushed through committees without sufficient research and input from affected parties on the impact that a particular bill would have if enacted. I found great delight in being placed in a position to ask questions and bring forth concepts on health care issues that had not been presented in the past. Many members of the House conveyed to me their gratitude in having representatives Nancy Kessel, D-Kanawha, John Huntwork, M.D., D-Cabell, and myself as resources on medical issues.

Politics is gamesmanship and we must know how to play. In my view, to be an effective player one must have power or influence on the issues. Power equates to the ability to make something happen or to keep it from happening. WVSMA did make it on the team this year because at the 11th hour of the session, some very key legislation did not pass that was considered damaging to physicians. In my opinion, the power structure of the West Virginia Legislature would realize a major upset if more Republicans were elected or if a significant turnover was created in the next election.

Being a legislator has been fun, frustrating and frantic -- all at the same time. On the sober side of serving, it carries a great responsibility since the issues decided by the Legislature involve the lives, dreams, security and health of our citizens.

Thank you for supporting me.

Delegate John Huntwork, M.D., D—Cabell

A great health care debate is taking place in our state and in our nation. If physicians are to participate in that debate, we must recognize that health care activism, however misguided and counterproductive it may thus far have been, is an honest response to a genuine need.

"Universal access to affordable health care" is a phrase of great emotional appeal, though every work is loaded with difficult connotations. Indeed, when this is stated not as a demagogic cliche but as a genuine goal which respects the rights of all parties and recognizes the sometimes painful consequences of bad choices in a free society, most physicians enthusiastically agree.

Individual physicians are often too immersed in the day-to-day struggle with our overregulated and litigious "health care system" to participate in the political process, but unless we become increasingly involved, acting from the humanitarian foundation upon which our great profession stands, we will continue to be pawns in a health care game dominated by unscrupulous insurance companies, powerful hospitals and ambitious politicians.

As a "freshman" delegate I still may be more a bench-warmer than a player, but I no longer feel excluded from the game or pessimistic about its outcome. Politically powerful individuals and groups have earned that power by their efforts over many years. Issues come and go; control of the process is the result of hard work. If what is good about American medicine is to survive, physicians must pay that price.

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Remarks at the 1990 WVU Investiture Ceremony

Editor's Note: *The following speech was given by distinguished educator Edmund B. Flink, M.D., Ph.D., at last year's Investiture Ceremony for the West Virginia School of Medicine. Dr. Flink is currently a Benedum Professor at WVU, where he was chief of medical service for 16 years until his retirement in 1976. Dr. Flink's remarks are reprinted here in honor of his outstanding career and as a special inspiration to all of the state's medical students graduating this spring.*

Dr. Flink

It is a pleasure for me to speak to you on this important occasion. Your families have a great investment of love, trust, and money in you. West Virginia has a large investment in you. We members of the faculty have a great deal of respect and admiration for your successful completion of the rigorous medical school course.

Dr. Eugene Stead has written "No greater opportunity, responsibility, or obligation can fall to the lot of a human being than to become a physician. In the care of the suffering, he needs technical skill, scientific knowledge, and human understanding. He who uses these with courage, with humility and with wisdom will provide a unique service for his fellow man . . ."

I wish to talk to you about scholarship in medicine in order to keep oneself informed in scientific knowledge and able to perform technical skills as they appear on the scene. Scholarship is the essence of a university. It covers the whole spectrum of human life, from philosophy and ethics, religion, literature, and the fine arts, to basic and applied scientific subjects — certainly medicine qualifies. Our scholarship should include some history of medicine and should enrich our lives, ensure the best possible care for our patients, increase our job satisfaction, and keep us humble. The real payoff is the satisfaction of a job well done. Seek something beautiful each day of your life.

In order to maintain scholarship, it is necessary to have the spirit of inquiry — to ask what? when? why? where? and how? We can learn about each patient by "Listen: The Patient" and "Look and See the Patient." Either physical or psychic pain is the commonest chief complaint of patients. Finding the cause of pain and relieving it is our major job.

Lord Lister, who introduced antisepsis, emphatically expressed the need for continued scholarship when he said to his students, "If you are not willing to learn and unlearn all you life through, you should abandon medicine." Sir William Osler emphasized the need for studying books and patients by saying, "To study medicine without books is like going to sea without charts, but to study medicine without patients is like not going to sea at all."

Louis Pasteur wrote, "Take interest I implore you, in those sacred dwellings which one designates by the impressive term laboratories. Demand that they be adorned — they are the temples of well-being and happiness."

I could spend an hour just listing the remarkable advances of molecular biology, application of basic physical sciences, and the enormous advances in treatment modalities since I graduated from medical school 53 years ago. I would be hopelessly lost if I hadn't kept trying to keep up.

One thing has not changed. The care of the patient requires patience, equanimity, and humility. I can illustrate this idea best by quoting from several sources.

Peabody delivered a talk entitled, "The Care of the Patient" to a class of students at Harvard University at the time of their graduation in 1927. In it he discusses many important aspects of the practice of medicine. It should be required reading. He concludes with the statement, "The secret of the care of the patient is caring for the patient." Note that the Greek "caritas" means love, and the words "charity" and "care" are derived from caritas and should mean love. Some patients, and more often their families, are difficult and provoke anger in caregivers. We must not allow ourselves to react adversely, but remember the root word "caritas." This is a very good statement about compassion. There are many statements about compassion and love in the world's literature and music. In the Sermon on the Mount, Jesus deals with many aspects of compassion and care — mainly for those who are in need of help, particularly in social spheres. When we deal with patients, we must listen to and look carefully at the patient so that we can know the patient as a person. Some of you will have little direct contact with the patients, but your work must comply with the idea of compassionate care.

One burden I'd like to leave with you. The very core of biologic research is being seriously threatened by a very vocal minority. They are trying to block the use of all animals in biomedical research. The accomplishments of the past century would not have been possible without use of animals. I implore you to let your patients know about the dangerous situation and that the humane use of animals in research is absolutely necessary for continued progress in conquering diseases in the future.

Polonius gave his son Laertes (Hamlet) sage advice when Laertes was leaving home to go to Italy. "This above all: to thine own self be true, and it must follow as night the day, thou canst not be false to any man."

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Parenteral and Oral Acyclovir for Management of Varicella Pneumonia in Pregnancy: A Case Report with Review of Literature

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Abstract

Varicella pneumonia is a relatively rare disease in the reproductive-aged woman, but has a reported 41 percent maternal mortality rate in pregnancy. Seventeen cases managed with intraveneous acyclovir are reviewed. We report successful management with the unpublished addition of oral acyclovir to complete antiviral therapy on an outpatient basis.

Introduction

Chickenpox or varicella is usually a benign, highly contagious disease of childhood caused by the varicella-zoster (V-Z) virus. In adults the illness is usually more severe. Although less than 2 percent of reported cases occur after the second decade of life, approximately 25 percent of deaths due to varicella occur in this age group (1). Thus, it is a relatively rare and potentially serious disease of the reproductive-aged woman. Reported complications of varicella in pregnancy include birth defects in the first trimester; herpes zoster in the infant exposed in the second trimester; and premature labor, maternal death and neonatal varicella in the third trimester (2-7).

Harris retrospectively reviewed the literature in 1965, prior to the advent of antiviral chemotherapy, and reported a maternal mortality rate of 41 percent when varicella pneumonia complicated pregnancy. This rate was in contrast to an 11 percent mortality when the same condition occurred in 236 non-pregnant adults. Estimates of the incidence of varicella pneumonia vary. A prospective study of young, male military personnel with varicella revealed that clinical respiratory symptoms were present in only 4 percent, but roentgenographic abnormalities were present in 16 percent (8). In a prospective study of 43 pregnancies complicated by varicella, Paryani and Arvin (1986) reported a 10 percent (4 cases) incidence of pneumonia resulting in one maternal death.

Acyclovir (9-[2-hydroxyethoxy-methyl]guanine) has been demonstrated to be an effective, non-toxic parenteral antiviral agent in the treatment of cutaneous or systemic herpes zoster in immunocompromised patients (9-10), and of herpes simplex infections of both premature and term neonates (11). The first reported use of parenteral acyclovir in pregnancy was for treatment of disseminated herpes simplex which was complicated by pneumonia, a consumptive coagulopathy and premature rupture of membranes (12). In this case and a subsequent case report of disseminated herpes which resulted in delivery at term, no fetal toxicities were noted (13). Landsberger (1986) then reported a case series of three pregnancies complicated by varicella pneumonia which were successfully managed using parenteral acyclovir; doses of 10-30 mg/kg/day for 10 days were utilized without significant maternal or fetal toxicity (14). A review of the literature reveals 14 subsequent cases of varicella pneumonia in pregnancy that were treated with intraveneous acyclovir (15-19). There was one maternal death when a dose of 5 mg/kg every eight hours was employed (19); successful managements were otherwise reported at doses of 10-18 mg/kg intravenously every eight hours. There were no cases of fetal toxicity, although neonatal death due to premature delivery has occurred.

To our knowledge, there are no published reports of the use of oral acyclovir in this setting to shorten the hospital course while completing effective antiviral therapy. Experience with oral acyclovir in herpes zoster infections is reviewed and its use in a case of parturient varicella pneumonia is reported.

Case Report

K.A., a 27-year-old white gravida 2, para 1,001 was seen at 26 weeks gestation by her obstetrician. She had been seen from 11 weeks gestation and her prenatal course had been unremarkable to date. With a three-day history of a pruritic, vesicular skin rash, she complained of progressive dyspnea, a dry cough, anorexia, myalgias and mild diarrhea. She denied contractions, ruptured membranes, or vaginal bleeding and the fetus was active. An infectious diseases consultation was obtained and she was subsequently admitted to the Charleston Area Medical Center.

The patient was initially afebrile, but developed a fever of 38.0°c shortly after admission. She was tachypneic, with stable vital signs and was noted to be an alert, white, gravid female with dyspnea on mild exertion. Physical examination was remarkable for a right erythematous conjunctivitis, the oropharynx was clear. Her lungs were clear and the abdomen soft, non-tender, with a fundal height of 24 cm and audible fetal heart tones on 150 beats per

Figure 1. Parturient vericella pneumonia

minute. The cervix was closed, thick and high. Her nail beds were cyanotic with exertion and the skin revealed a diffuse vesicular rash of the face, trunk and extremities consistent with varicella. She denied any prior history of varicella and reported exposure to children, which later developed chickenpox.

Laboratory data revealed a WBC of 6,900 (56 PMN, 15 bands, 23 lymphs, 3 atypical lymphs, 3 monocytes). Hemoglobin was 11.2 mg/al and hematocrit was 31.2 percent. Platelets were 121,000. Prothrombin and partial thromboplastin times, electrolytes, liver enzymes, creatinine and urinalysis were normal. Arterial blood gases at bedrest on room air were pH 7.44, pCO_2 28, pO_2 82 and bicarbonate 19. A sputum culture was obtained which ultimately grew normal flora. Chest radiography revealed diffuse, bilateral nodular and linear interstitial changes (see Figure 1).

A presumptive diagnosis of varicella pneumonia was made. She was placed in respiratory isolation in a negative airflow room. Intravenous acyclovir, 625 mg every eight hours (12 mg/kg/dose) was begun while maintaining adequate hydration. Supplemental oxygen was provided. Diphenhydramine (Benedryl) and liquid tears were provided for patient comfort. Hematologic surveillance included daily complete blood count and creatinine levels. The diagnosis was confirmed by a positive direct fluorescent antibody to V-Z virus, made by aspiration of several vesicles.

The patient defervesced rapidly after initiation of acyclovir therapy and subsequently remained afebrile. New crops of vesicles appeared through her third day at the hospital, at which time her respiratory symptoms had resolved allowing discontinuation of oxygen therapy. Her creatinine level remained stable, the platelet count rose to 300,000, but her hemoglobin level fell to 9.1 mg/dl during her hospitalization. A repeat chest radiograph on hospital day 5 was essentially unchanged. The patient continued to feel well; however, all lesions had crusted over and she was discharged home on the sixth day since admission. Her discharge medications included iron and a five-day course of oral acyclovir, 600 mg every six hours. Therapeutic peak levels of 4.73 umol (1.06 mcg/ml) were achieved with oral therapy. At the conclusion of this regimen, the patient continued to feel well and her hemoglobin and hematocrit levels had risen to within normal limits.

The remainder of her prenatal course was unremarkable and she delivered at term an appropriate for gestational age male infant without anomaly or evidence of cutaneous lesions. At birth, a moderate level of IgG (0.52) to varicella-zoster virus was detected in the cord blood, consistent with passive transfer of maternal antibodies. No IgM (<0.05) antibody was detected. At one month of age, the infant is well and without evidence of disease.

Conclusion

Preclinical toxicology studies have shown acyclovir to be a remarkably non-toxic and highly selective antiviral agent. Secondary toxicity in the precipitation of crystals in the distal nephron, causing reversible azotemia after rapid intravenous injection, is well-documented in animal and human studies and can be easily managed with adequate hydration and slow parenteral administration. Also reported are injection site pain or localized phlebitis, nausea and rash (10). No major anaphylactic reaction has been reported. Standard teratology assays, neonatal toxicity studies and a two-generation reproduction-fertility study in animal models have not revealed evidence of impairment to reproductive and developmental processes. Acyclovir showed no activity in the AMES plate assay and in three cultured-mammalian cell assays for gene and chromosomal damage, even in enormous doses (20). Three in vivo mammalian assays for chromosomal damage were likewise negative. Studies of human pregnancy and acyclovir are limited by ethical and methodologic limitations. However, in the clinical experience reported here and in the preliminary findings of the Acyclovir in Pregnancy Registry (21), in which 49 prospective cases have been followed to term, no abnormalities attributed to acyclovir have been reported. Definitive data on the safety and efficacy of acyclovir in human pregnancy are as yet, unavailable.

Brown and Baker (22) have recently reviewed the literature on acyclovir use in pregnancy and recommend IV acyclovir 7.5 mg/kg every eight hours for treatment of maternal varicella pneumonia. They note however, that definitive dosing schedules await prospective trials. Dorsby and Crumpacher (23) note that intravenous dosing of acyclovir 5 mg/kg every eight hours will result in trough levels that fall below the ID_{50} of 3.5 umol for varicella-zoster isolates, and that 10 mg/kg/dose may give better results. Balfour (24) also recommends acyclovir 10 mgk/kg/dose of ideal body weight, to be given intravenously for at least seven days in treating disseminated or visceral varicella in immunocompromised adults. Finally, Peterslund (25) has recommended a dose of 10 mg/kg per eight hours for five days in varicella pneumonia of the immunocompetent host, best results were obtained when treatment was initiated within 96 hours of the rash.

We obtained good results with acyclovir 12 mg/kg per dose, or approximately 10 mg/kg of ideal body weight for five days. As noted previously, intraveneous hydration was continued and rapid bolus administration was avoided. No

elevation in the serum creatinine was noted during treatment, although a transient fall in the hemoglobin and hematocrit did occur.

The necessity for intravenous administration of acyclovir has restricted its outpatient utility. Placebo-controlled trials with oral acyclovir for herpes zoster infections have been reported. At doses of 600-800 mg five times per day, significant effects were noted in shortened periods of viral shedding, accelerated time to lesion scabbing and healing, reduced pain, and less frequent formation of new lesions (26-27). No significant hastening of rash healing was noted in those who started therapy later than 48 hours after the onset of rash (28).

In this case report, there was marked improvement in respiratory symptoms and complete lesion scabbing after the initial five-day course of intravenous acyclovir. However, the chest radiograph showed only modest improvement and we felt that continued viral suppression with oral acyclovir was warranted. A dose of 600 mg four times daily was chosen due to concern for the patient's falling hematocrit. Bone marrow depression by acyclovir has not been reported, other more likely etilogies included hemodilution or marrow depression by the VZ virus itself. A five-day course was completed without adverse effects and therapeutic drug levels were achieved. The remainder of her prenatal course was unremarkable and the patient subsequently delivered at term without evidence of fetal toxicity.

In summary, prompt recognition and initiation of appropriate parenteral antiviral therapy is crucial to the successful management of varicella pneumonia in pregnancy. Direct fluorescent viral antibody smears are now available for rapid verification of the diagnosis; however, therapy should not be delated for this purpose. Respiratory isolation in an institution capable of providing respiratory intensive care is required. After the completion of a five-day course of parenteral acyclovir, if respiratory symptoms have resolved and the patient's cutaneous lesions are dry, consideration may be given to completing therapy with a course of oral acyclovir as an alternative to further hospitalization. Definitive dosage recommendations await further clinical experience in this setting.

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Adolescent Perceptions of Teenage Morbidity and Mortality in a Rural Population

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Abstract

Health-related questionnaires were administered to 742 high school seniors in small towns in rural West Virginia. Students tended to overestimate the immediate threat to their health from cancer, heart disease and AIDS. They recognized a threat from auto accidents to their life and health in the immediate future, but nevertheless indulged in high-risk drinking and driving behavior. A surprisingly high percentage were concerned about stress and depression (40 percent) and suicide (11 percent). One-third of students had either planned or attempted suicide, suggesting that appropriate health education for this age group should include more emphasis on psychosocial issues and stress management.

Introduction

Although teens share many types of problems with adults, any approach to these problems must take into account the social and developmental factors unique to adolescents. Recently, considerable interest has been generated concerning the health needs of adolescents based on national and regional surveys (1). Most of this information comes from urban and surburban settings (2,3,4), with little data derived from small towns or rural areas. This survey was conducted in three West Virginia high schools to gather information on the health needs of adolescents in small towns and rural areas and compare it with national data.

Nationally, statistics have been compiled documenting contemporary threats to adolescent health that note over the past 30 years there has been a shift in the causes of mortality from "communicable to social" etiologies (2). Accidental injuries and violence are the primary cause of death for children and young adults. The risk of such injuries increases with age and the majority of these injuries (60 percent) are related to motor vehicle accidents. Homicides have tripled, and suicide attempts have quadrupled (with about one in 10 attempts resulting in death). Annually, one in 10 adolescent girls become pregnant, one third of these by an adolescent male. Safety was found to be a low priority since only 12 percent of these teens were using seat belts regularly, 9 percent were driving while drunk, and one in seven were drinking to inebriation at least weekly (2). Half of the teens admitted worrying about psychological and social problems and stated that they were concerned about stress and nervousness.

The National Adolescent Student Health Survey (1) conducted on 8th and 10th graders in 217 schools in 20 states reported similar findings. Seventy-eight percent of girls and 89 percent of boys has used alcohol. Over half of these adolescents did not use seatbelts during their last car ride and 32 percent had ridden with a drunk driver in the prior month. Thirteen to 16 percent reported experiencing a physical attack. Twenty-five percent of boys and 40 percent of girls reported considering suicide at some time in their lives, and 11 percent and 18 percent had actually tried to injure themselves.

Methods

Seniors from three high schools (Morgantown, Buckhannon, and Clay-Batelle) in two northern West Virginia counties completed a 22-question survey. Approval of the school boards, principals, and parents was obtained prior to testing. The survey was given to 757 students and completed by 742 for a response rate of greater than 98 percent. Due to the sensitive nature of the material, responses were anonymous and students were not obligated to answer any or all of the questions. Questionnaires required less than 15 minutes to complete and no class discussion was held.

Surveys were coded and data compiled and analyzed for gender and school differences by X^2 and F test analysis. The age range of the respondents was 16 to 19 with a mean of 17 years. Fifty-one percent were male and 49 percent were female. Ninety-six percent were white and two percent were black. No socioeconomic data was obtained.

Perception and Health Problems

When asked to identify two problems on a list which might pose a threat to their life in the next two years, 79 percent chose auto accidents, 26 percent chose cancer, 15 percent chose heart attack, 13 percent AIDS, and 11 percent suicide. When asked about two problems which might pose a threat to their general health in the next two years, 49 percent chose auto accidents, 40 percent stress or depression, 22 percent smoking or tobacco use, 18 percent alcohol use, 14 percent excess weight, 8 percent pregnancy, 5 percent STD's, and 4 percent drug use.

Twenty-six percent identified stress and/or depression as a problem for which they would like help but have not sought assistance. This was closely followed by family problems (21 percent) and excess weight (20 percent). Skin problems (12 percent), contraception (11 percent), tobacco use (9 percent), and alcohol use (7 percent) were also listed as concerns with drug use and STD's (3 percent) being perceived as lesser concerns. Thirty-one percent of seniors reported using some form of tobacco and 19 percent reported being regular smokers. Of these, 55 percent were females and 65 percent reported smoking less than half a pack per day.

Eighteen percent of seniors reported drinking to the point of intoxication once a month. Fifty percent reported being in an automobile while drinking and

23 percent drove a vehicle while drinking. Nineteen percent never used seatbelts and 35 percent buckled up occasionally, while 46 percent did so always or most of the time. Males were less likely to use seltbelts with 29 percent never using them and only 16 percent of males always using them vs. 25 percent overall. Males were significantly ($p < .05$) more likely than females to have been driving while drunk (32 percent vs. 14 percent), both were equally as likely to have been in an automobile while drunk (roughly 50 percent).

Seventeen percent of males and 32 percent of females report considering suicide or formulating a suicide plan but not attempting it. Six percent of males and 10 percent of females made a suicide attempt.

Drug use was reported by 14 percent of seniors with 3 percent of users claiming daily drug use and 8 percent using drugs several times per week. Most drug users (58 percent) characterized their drug use as occurring rarely or less than monthly. No data was obtained on the types of drugs used.

Just under 5 percent of females report having been pregnant with an equal number of those experiencing abortions and miscarriages (27 percent), and 44 percent reporting a live birth. Thirteen percent did not answer the questions on contraception and the one-third who responded always used contraception (specific method was not requested) and 22 percent reported occasional use. Ten percent never use contraception and one-third of responders said they weren't sexually active.

Of those reporting drinking to intoxication once a week, 22 percent indicated they would like help dealing with alcohol but had not sought help; 26 percent of regular smokers also reported a desire for help to quit smoking. Over half of those who reported planning but not attempting suicide, indicated that they would like assistance with depression and emotional upsets but have not sought help. Eighteen percent of regular drug users also wanted assistance but haven't sought help.

Access to health care did not appear to be a major problem, as 74 percent had seen a physician in the prior 12 months and 89 percent in the prior 2 years. The reasons for these visits included a specific medical problem (45 percent), sports physical (32 percent), and routine exam (22 percent).

Discussion

Although living in small towns and rural areas, the West Virginia seniors surveyed share many characteristics with other adolescents. According to 1985 U.S. Vital Statistics and 1987 West Virginia Statistics, accidents comprise a larger percentage of deaths in youths 15 to 24 in West Virginia than the national average (67.1 percent vs. 53.5 percent). Homicide and suicide make up a lower proportion of deaths in West Virginia compared to national figures (6.5 percent vs. 13.5 percent and 7.1 percent vs. 12.3 percent respectively). The percentage of death from malignancy is lower (2.9 percent vs. 5.5 percent), while the percentage of deaths from cardiovascular disease is comparable (3.2 percent vs. 3.6 percent).

The teens surveyed correctly perceived auto accidents as the leading threat to their life and health over the next two years, but a significant number continued to indulge in high-risk behavior such as drinking and driving or not using seatbelts. Fourteen percent of these West Virginia seniors drank to the point of intoxication, a percentage similar to that reported by Blum (2). A substantial percentage (46 percent) used seatbelts "more than occasionally" in West Virginia, a much higher percentage than reported by Blum (12 percent). The prevalence of cigarette smoking was 19 percent in West Virginia seniors vs. 26 percent in 10th graders in the National Adolescent Health Survey (2). It is not clear what factors contribute to more frequent use of seatbelts or infrequent adoption of smoking in West Virginia.

Students tended to over-rate the immediate threat to their life due to cancer and heart disease. These responses may reflect an awareness of health education messages based on adult mortality statistics, rather than information based on specific risks to teens. Very realistic perceptions regarding threats to health from auto accidents (49 percent) and stress or depression were expressed. In addition, the fact that the seniors cited tobacco use and alcohol use as potential threats to health means that they have received education on these health risks sufficient to increase knowledge and affect attitudes.

West Virginia teens were just as likely to consider suicide although they were less likely to attempt it (8 percent vs. national figures of 14 percent); however, the 33 percent of teens who have either planned for or attempted suicide is a statistic of great concern. This figure is supported by the 40 percent who felt that stress or depression might be an immediate threat to their health. It appears students are being educated about traditional health and medical concerns, but not about addressing mental health issues such as stress management, interpersonal relationships, decision-making skills, self esteem, etc. It would appear that psychological and social well-being needs to be addressed for all students, not just for those identified as "problem" students, since such a high percentage have concerns in these areas. Programs to foster emotional well-being are just as important and perhaps more urgently needed than education on some other health topics. In addition, it appears that the traditional medical model may not adequately address these issues, because most teens do have access to medical care at the current time but still express unfilled needs. Some pediatricians and family physicians make a special effort to develop the counseling and interpersonal skills required to address these needs, but in some studies students have expressed and demonstrated a resistance to seeking help for "non-medical" needs from physicians (3).

The prevalence of drug use reported in this survey is difficult to compare to national figures, but West Virginia students do not perceive drug abuse to be as significant a problem as do urban youth in economically impoverished neighborhoods. The percentage of girls who report having been pregnant is low compared to

national estimates that 10 percent of teen girls become pregnant each year. It is unknown whether this may be due to denial as there is no way to verify accuracy of questionnaire responses, or to the possibility that some girls who became pregnant are no longer attending school. The northern counties have a lower teen birth rate than other areas of the state, which averaged 55 live births per 1,000 women age 15-19 in 1989. It is difficult to compare birthrate statistics from different sources due to differences in statistical methods. According to 1985 MMWR figures (5), West Virginia has a pregnancy rate for teens lower than the national average, but one of the higher birthrates, suggesting that abortion is utilized less frequently here than in other parts of the U.S.

In comparing the three schools, there was no significant difference in reported rates of cigarette smoking, weekly drinking or suicide, using the F test for significance of difference in proportion. There was a significant ($p > .05$) difference in the use of smokeless tobacco with the most rural school leading the others in rate of use (28 percent). There was also a significant difference in the reported rate of "always" using seatbelts with the university town having the highest use (34 percent).

In summary, state seniors in small towns and rural areas share problems seen in teens in other areas of the country, such as mortality due to motor vehicle accidents, and drinking alcohol. They are just as likely to be troubled by psychosocial or family problems and to consider suicide, although actual suicide rates are lower than national reports. Students appear to be receiving education on diseases such as cancer, heart attack and AIDS and also recognize auto accidents and alcohol use as threats to life and health. Even so, health risk behavior is not unusual and the prevalence of suicidal thoughts and actions should be a great concern.

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Manuscripts to be presented for publication in the *West Virginia Medical Journal* should be prepared in accordance with "Uniform Requirements for Manuscripts Submitted to Biomedical Journals" (1) (International Committee of Medical Journal Editors).

The *West Virginia Medical Journal* will not consider for publication a paper or work that already has been reported in a published paper, or is described in a paper submitted or accepted for publication elsewhere.

Manuscripts, accompanied by one copy, should be typewritten, double-spaced, on one side only of white bond paper (8½ by 11 in.), with margins of at least one inch.

Use double spacing throughout, including (in the following order) title page, abstract, text, acknowledgements, references, tables, and legends for illustrations. Begin each of the following sections on separate pages: title page, abstract, text, acknowledgements, references, individual tables, and legends for illustrations. Number pages consecutively, beginning with the title page. Type the page number in the upper right-hand corner of each page.

Articles contained on computer diskettes are acceptable and encouraged. Please contact the *Journal* in advance to determine the format type to be used. The conventional manuscript as described above must accompany the diskette.

All persons designated as authors should qualify for authorship. Each author should have participated sufficiently in the work to take public responsibility for the concept.

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Tables (tabular listings) and figures (photos, drawings and charts) should be numbered and the point of reference in the text indicated in parentheses, i.e., (Table 1), (Figure 1).

Photos must be good-quality unmounted glossy prints usually 5 by 7 in. but no larger than 8 by 10 in. Black and white photos are preferred. Color photos will be printed in black and white. Cost of printing photos in excess of four will be billed to the author.

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Number references consecutively in the order in which they are first mentioned in the text. Identify references in text, tables, and legends by arabic numerals (in parentheses).

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Use the style of references seen in this *Journal,* which is based on the formats used by the U. S. National Library of Medicine in *Index Medicus.* The titles of journals should be abbreviated according to the style used in *Index Medicus.* Consult "List of the Journals Indexed," printed annually in the January issue of *Index Medicus.*

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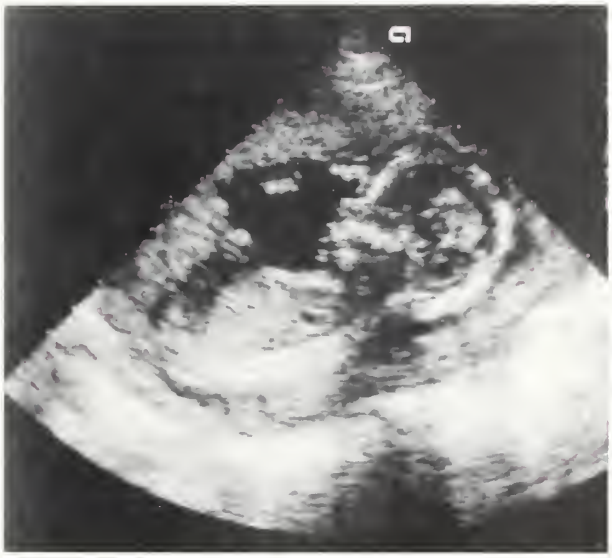

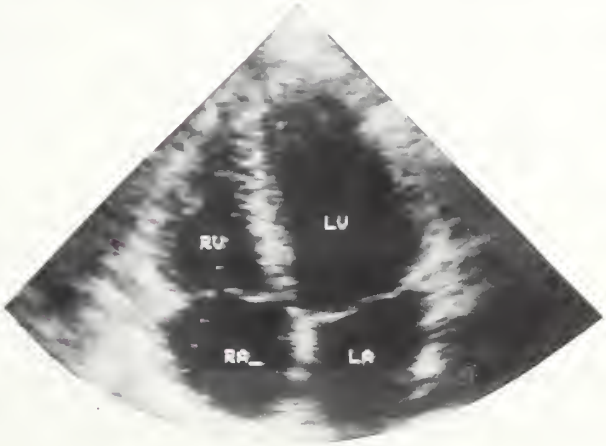

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President's Page

Michael M. Stump, M.D.

Opinions and Perceptions

Fascinating gaps are emerging in 1991 between patients' perceptions of their own physician and "physicians in general."

For example, 85 percent of West Virginia patients say they have faith in their doctor, but 74 percent say people are losing faith in doctors. Can this apparent discrepancy be explained? Yes, I believe it can, but first let's examine some other results from the recent Gallup poll of 400 West Virginians. The 95 percent confidence level of this random sample poll is + or − 4.9 percent.

Sixty-eight percent of those polled said doctors are too interested in making money, but 75 percent said their doctor is not too interested in making money. Thirty-nine percent felt doctors act like they are better than others, but 89 percent said their personal physician does not. Thirty-two percent said doctors do not explain well, but 84 percent said their doctor gives them thorough explanations. Only 26 percent said doctors spend enough time with them, but 80 percent said their doctor does devote enough time to them. Interestingly, Gallup reports the medical profession as a whole was most poorly evaluated by younger respondents, as well as downscale and less-educated citizens and females.

When patients were asked about their last office visit, 73 percent were very satisfied with their doctor's staff; 22 percent were somewhat satisfied; 92 percent were very or somewhat satisfied overall with their visit; 90 percent were satisfied with their medical care, 88 percent were satisfied with their doctor's explanations; 84 percent were satisfied with the waiting time to get an appointment; 83 percent were satisfied with the waiting time to see the doctor; and 74 percent were satisfied with the fee.

In response to the question "Compared to other industrialized countries, do you think Americans receive better health care, the same health care, or worse health care than people in other industrialized countries?" only 13 percent said they had worse health care; 56 percent said better health care, 14 percent said the same health care, and 17 percent were unsure.

On April 8, the AMA News Report of the 1991 National Gallup Survey showed that the public's favorable opinion of their personal physician is rising as compared to the last survey in 1983. At the same time, there is some decline in the public's opinion of doctors in general.

In the beginning, I posed the problem of examining the discrepancy between the public's perception of their personal physician and their perception of all physicians.

I believe that patients know from actual face to face experience how their personal physician deals with them. The individual patients know the facts because they were there. In the case of the profession as a whole, patients can know only by heresay and imagery, by what they are told by certain persons in government, by what they read, or by what they see on television.

People need to understand that the profession has been under sociopolitical assault for over 40 years. They must accept the fact of the liberal social bias of most editors, writers and reporters in the media and realize their bias favoring socialization and social solutions. They must also accept the fact that this acts as a filtering mechanism to enhance liberal social ideas and diminish conservative social ideals.

The main and strongest defense against this social bias is the relationship of the individual physician with the individual patient. The physician's attitude, behavior, communication and even the explanation of fees significantly govern the relationship between the physician and the patient.

The other defense against the bias is medical and community citizenship by the physician. It is essential to be involved in the community as a participating citizen, involved in indigent care, involved in free clinics, involved in wellness, involved in solving the common problems facing our patients in health and well-being, as well as in education and jobs.

The WVSMA, its members and auxiliary are following the path of involvement with these needs. We are moving forward on that path searching for working solutions. We, as well as the others who will follow us, owe a great debt to those who have given and are giving so much.

We shall continue on the path.

Michael M. Stump, M.D.

Editor's Note: *Dr. Stump's March message "The Yellow Brick Road," was reprinted in the March 14 edition of The West Virginia Hillbilly.*

West Virginia Teenagers

We bring your attention to the scientific article on page 207, "Adolescent Perceptions of Teenage Morbidity and Mortality in a Rural Population." Like a Bruegel painting depicting 17th century small-town Dutch life, this article captures a view of current, small-town teenage life in West Virginia.

The statistics given in the discussion suggest that West Virginia teenagers are, in fact, different in many ways from those aliens outside our borders. Accidental death statistics suggest that life is somewhat more rugged here but the figures also might suggest, as a cause of those statistics, the deplorable condition of some of our rural highways. The Hatfield and McCoy image of low regard for life is belied by the statistics indicating that West Virginia has about half the homicide mortality recorded among teenagers elsewhere. Then too, our teenagers might be significantly happier than others in that our suicide rate is significantly lower. The lower malignancy death rate suggests that West Virginia's environmentally-polluted and garbage-ridden condition has yet to show its lethal effects, at least on our youth.

Responses in regard to drug use perhaps suggest that West Virginia teenagers can say "No" more often than some of their city cousins. The same seems to apply to teenage girls in matters relating to sexual activity, and even abortion.

Several worthwhile suggestions are made pursuant to findings in the study. Articles based on statistics usually bore us. This one does not.

—SDW

Medical Students Are Saying "No" to Practicing in West Virginia — What Can Be Done About It?

I am a senior medical student at West Virginia University. In the March issue of the *West Virginia Medical Journal,* a letter was published I wrote to Governor Caperton, House Speaker Chuck Chambers, and Senate President Keith Burdette explaining why medical students are leaving West Virginia. As a follow-up to that letter, I have outlined below some changes that would aid in the effort to keep medical students committed to practicing here.

Two points are key to a successful recruiting effort. First, the decision where to practice is often made very early in training, even before a specialty is chosen. Second, during the first two years of training, medical students are strongly influenced by anything a physician says. These factors combine to make the first two years of medical school an ideal time to convince students to stay in West Virginia. A concerted effort during this period on the part of the medical schools, backed by the state, would yield the highest rewards.

1. West Virginia's medical schools, even in their student recruiting literature, must be clear and up front about their objectives. They must make a strong statement that their primary purpose is to train physicians, and their second objective is to train them for West Virginia. This theme must be emphasized during first-year orientation. Recruiting doctors for West Virginia needs to begin here.
2. This message must be reinforced throughout the four years of medical school by:
   a. Regular newsletters for students on what's happening in health care in West Virginia. To be effective, this material must be included on exams. If included as "extra credit material," it would be particularly well received by students. Newsletters would serve the dual purpose of teaching medical economics, and keeping West Virginia medicine in the forefront of students' minds.
   b. Monthly guest speakers addressing issues beyond academic medicine: These speakers could include legislators, insurance personnel, attorneys and health care administrators, as well as physicians. These discussions should focus on the multi-dimensional aspects of health care in West Virginia. They must be held in lieu of regular classes, which would reinforce their importance in the eyes of students.
   c. Greater emphasis in the formal curriculum on issues in medical economics, with particular application to our state: A problem-solving or debate-style approach would bring these issues alive. Innovative educational curriculums may already be available, a possibility which deserves investigation. Such an effort would see the benefit of graduating new physicians well versed in the complex issues of today, with a knowledge base from which to make a political impact on health care issues. These skills are critical in the current health care climate in this state. Tomorrow's physicians will be forced to leave the security of the hospital and examining room, and the best prepared will be the most effective spokespersons for their patients and their profession.
3. The reasons physicians practice in rural West Virginia are intangible ones - family service, small-town community atmosphere, slower and simpler lifestyle, etc. The best people to "sell" these intangibles to impressionable first and second-year medical students are the rural physicians and their patients. These rewards will best be appreciated by students as they work side by side with physicians, watching them interact with patients and hearing anecdotes about practice in rural areas. The student who is asked time after time by the patients he or she meets, "Are you going to stay here?" will be the one who truly understands the desperate need for rural physicians. Let the physicians and the patients in rural West Virginia recruit their future doctors!

   At one out-of-state medical school with which I am familiar, first and second-year students spend one day a week in a clinical setting. The same concept could be intergrated into West Virginia curriculums. At WVU, we were taught in six-week blocks. Change these to seven-week periods, with the seventh week spent in a rural practice. There should be time to do eight of these clinical weeks in the first two years, two in each of the primary care specialties — family practice, internal medicine, pediatrics, and obstetrics/gynecology. Basic science course material can be condensed to be covered in the shorter time, as has been done quite successfully at the out-of-state school. Every physician who has been through the grind of the basic science years will appreciate the impact this experience would have on the student. It has the potential of recruiting top college students to our medical schools.
4. "Recruiting tools" are in place now in our medical schools. Board of Regents' medical student loans are available to in-state residents. These are low-interest loans of $3,000 to $5,000 per year, with

forgiveness of up to $5,000 per year for each year of practice in underserved areas of West Virginia. However, this loan program needs better publicized. Information should be sent to all college seniors upon acceptance as medical students. Further, the list of qualified underserved areas needs updated. The conditions and requirements of the loan need to be more clearly spelled out. The benefits of correcting these administrative problems are obvious.

5. The Board of Regents' loan is available only to state residents. I know of one classmate who was born in West Virginia and has many relatives here. However, her parents now live out-of-state and thus she is a non-resident. As a first-year student, she planned to remain in West Virginia to practice. She attempted without success to obtain this loan and is no longer planning to practice here -- another physician lost for West Virginia. The purpose of this loan program needs examined. If physician recruiting is the goal, it should be available to all students.
6. The tuition paid by medical students is only a token of the true cost of the education, that is, only a token except to the student paying it. The state should capitalize on this difference in perspective of the relative value of these tuition dollars. Offer non-residents an in-state tuition rate with payback time required as payment of the difference — one year of practice for each year of in-state tuition awarded. The state would lose little in terms of dollars compared to what it might get in return in physician services.
7. West Virginia must actively recruit third and fourth-year medical students to residency programs within the state. I am speaking here of a recruiting effort initiated by the programs, not those initiated by fourth-year students in anticipation of residency interviews. I was personally recruited by family practice programs in both Pennsylvania and Ohio, yet my contact with West Virginia programs was limited to informal connections developed through residents while doing student rotations. Home state programs have a built-in advantage. The state must capitalize on it. Spend a little money to bring third and fourth-year students to see primary care residency programs. Sponsor dinners. Do <u>something</u> to tell students, "We want you here." This effort should be state financed and coordinated. It does make a difference. Medical schools can help in this effort by encouraging students to attend these functions, and by making released time from rotations available, even during the third year.
8. The new Residency Scholarship Program needs better publicity. In this program, selected rural hospitals make sizable scholarship awards to residents during their training, regardless of where the resident elects to train, in return for years of service in the rural community which feeds the respective hospital. This program should be explained to first-year students, and pushed hard in the third year. Rural hospitals need to expand their recruiting efforts by offering unique and interesting fourth-year elective rotations that would encourage students to live in their communities for a month.
9. Approach the annual legislative "medical school funding battle" and other issues relevant to medical education with an eye toward how the process itself affects physician retention. What's needed most is a change in attitude. The recent legislative battle regarding the restructuring of medical schools, though it resulted in little actual change, hurt this state very badly. It certainly lost the state more future doctors. It went even further than the Omnibus Health Care Act — it lost the state future medical students as well. The best qualified will go outside West Virginia for their education. They will choose not to risk their medical education and subsequently their future careers in a place where the state's leaders are insensitive to the complex factors that must be considered when making changes which affect medical education.

   The recent statewide debate on consolidation of medical schools illustrates well what I mean by a needed attitude change. Governor Caperton based his efforts to restructure medical education on an attack on medical schools for failing to train primary care physicians and failing to subsequently keep them in the state (see March issue of the *West Virginia Medical Journal).* With this approach, he immediately put the medical schools on the defensive and set the tone of the entire issue as one of confrontation instead of cooperation. A better alternative might have been to use the Carnegie study's recommendations as the basis of his attempt to consolidate schools.

Progress in solving the economic health problems in our state is the long range solution to the physician retention problem, but something can be done now. The ideas outlined here are relatively inexpensive and chiefly administrative. They require a restructuring of priorities to make "more physicians for West Virginia" a primary goal. As a student who has just completed her formal education, I know that the implementation of the ideas described here would have made an impact on me.

Traditionally, medical students have been in a position where we have little input into our system of medical education, and virtually no power to make changes. Hopefully, those who are in a position to make changes will consider these suggestions, then take the actions that will ultimately result in better health care for West Virginia.

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Renown Neurosurgeon to Give Harris Address at Annual

John M. Tew Jr., M.D., FACS, professor and chairman of the Department of Neurosurgery at the University of Cincinnati Medical Center and Mayfield Neurological Institute, will present the Thomas L. Harris Address on August 17 during the Second Session of the House of Delegates at the WVSMA's Annual Meeting at The Greenbrier.

Dr. Tew's medical career began in 1961 when he graduated from the Bowman Gray School of Medicine in Winston-Salem, N.C., and started his internship at Cornell Medical Center in Ithaca, N.Y. From 1962-63, Dr. Tew was a general surgeon resident at Peter Bent Brigham Hospital in Boston before becoming a clinical associate at the National Institute of Neurological Diseases and Blindness in Bethesda, Md.

In 1965, Dr. Tew accepted a position as clinical associate in neuropathology with the Armed Forces Institute of Pathology in Bethesda for one year, prior to returning to Boston to work as a clinical research assistant at Massachusetts General Hospital and then as a neurosurgery resident at Peter Bent Brigham Hospital. From 1968-69, he continued his postgraduate studies at Massachusetts General Hospital as a neurosurgery resident and the following year studied microneurosurgery in Europe as the recipient of a fellowship by the American Association of Neurological Surgeons.

After returning from abroad in 1970, Dr. Tew moved to Cincinnati to join the staff of the University of Cincinnati as an instructor in surgery. Five years later he accepted additional responsibilities as chairman of the Neurosurgery Department at Deaconess Hospital.

Dr. John M. Tew Jr.

In 1977, Dr. Tew was named to two of his current roles as both the director of graduate medical education in neurological surgery and chairman of the Neurosurgery Department at Good Samaritan. Since 1982, Dr. Tew has also been professor and chairman of the Department of Neurosurgery at the University of Cincinnati and chief of neurosurgery at Children's Hospital Medical Center.

Dr. Tew is very active in medical education activities and serves as a trustee for the Foundation for International Education in Neurological Surgery, Inc., and is a representative for the Association of American Medical Colleges. A noted lecturer, Dr. Tew has spoken extensively at conferences in the U.S. and around the world. In addition, Dr. Tew has been a visiting professor in over 10 foreign countries and is a colonel in the U.S. Army Reserves.

Dr. Tew's lecture is entitled "The Physician As a Caring Citizen: Being More Than 'Just Good.' " It will be the 19th Thomas L. Harris Address presented since this lecture was initiated at the 1973 WVSMA Annual Meeting.

Dr. Harris was president of the WVSMA in 1945, a difficult year due to the many problems created by the massive movement of physicians to the armed forces. His service to his county society and the WVSMA proved equal to the task. Until his death on July 11, 1972, Dr. Harris continued to provide active service and dedication to West Virginia medicine.

Dr. Harris attended annual meetings faithfully because he firmly believed in their value to the practicing physician. In his will he established a trust fund, the income of which was to be used to enhance the members interest in the annual meetings. The WVSMA Executive Committee decreed that the funds be spent to provide an outstanding speaker to keynote the annual meeting, and that the address be titled in Dr. Harris' honor to enshrine his name at the meetings.

During his career, Dr. Harris was a member and then later, chairman of the WVU Board of Governors. He was a founding father of the School of Medicine and played an active role in planning and staffing the school.

Dr. Harris had a strong sense of responsibility to his profession and community, and exemplified this in many ways, such as his generous support of civic programs and donating his time and money to the underprivileged. Many children received their education through his benevolence.

For information about any of the annual meeting events, please contact Nancie G. Divvens at the WVSMA office at 925-0342.

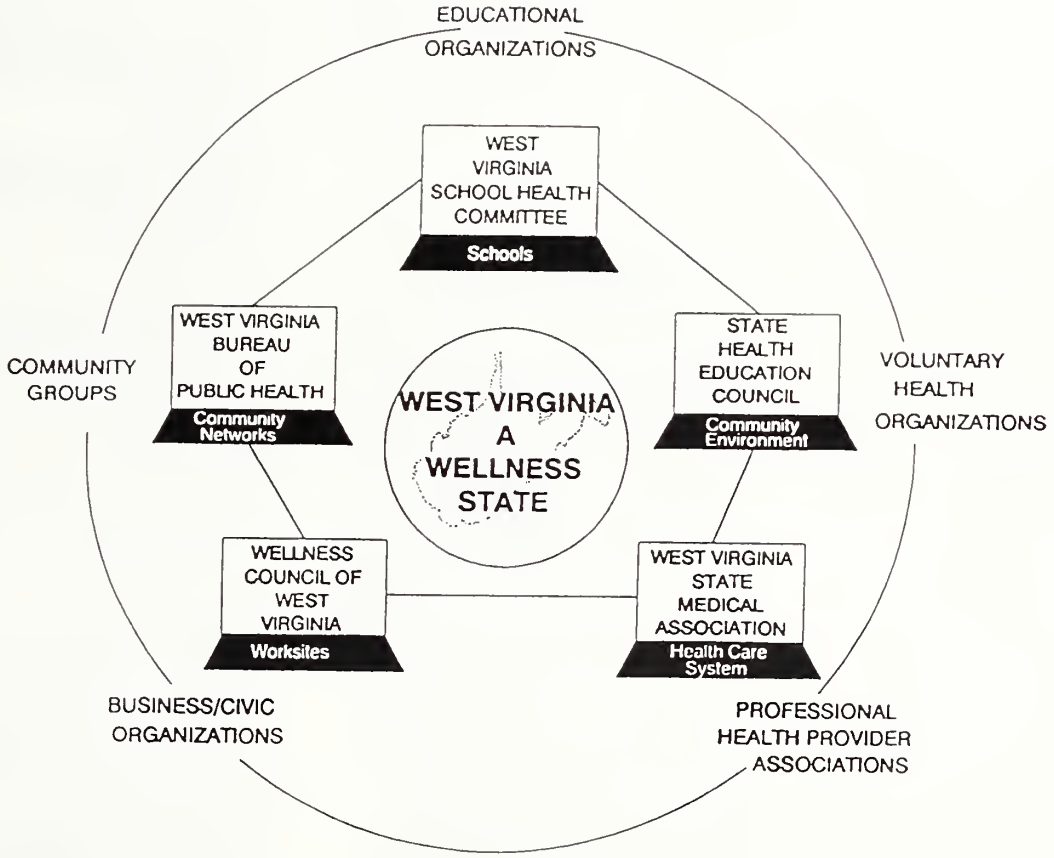
Five Organizations Unite to Form Wellness Coalition

More than a year ago, the West Virginia State Medical Association formed a Wellness Committee to work on programs throughout West Virginia after recognizing the success of the Bayer Wellness Program in Wellsburg. This committee, which included a WVSMA Auxiliary representative, met in various locations throughout the state. The group was attempting to identify physicians in each region to direct wellness programs.

It became apparent that many public and private organizations were already working on wellness programs and that there was a need to consolidate efforts in order to affect change in West Virginia's health status. Following a series of meetings with these organizations and WVSMA's Wellness Committee, a Wellness Summit sponsored by the WVSMA, was held in Charleston in late January where Governor Gaston Caperton and Senator John D. Rockefeller IV declared West Virginia a Wellness State. Health care professionals from around the state gathered in Charleston that day to meet others in this effort and learn what resources were in place. (Please see the March issue of the *Journal.*)

The culmination of this endeavor has resulted in the development of a framework for forming the West Virginia Wellness Coalition. The diagram below clarifies the channels or organizational framework through which specific wellness programs can reach targeted groups. The coalition will evolve around a core group of five organizations whose missions unite the five essential elements of the coalition. Namely, the five organizations are the Bureau of Public Health, Wellness Council, School Health Committee, State Health Education Council and WVSMA. The elements are the educational and voluntary health organizations, community groups, worksites and professional health provider associations.

First, the committee will develop a comprehensive plan which includes a study that will be completed by November and presented to the Bureau of Public Health. To facilitate the implementation of the plan, the Bureau of Public Health will appropriate $18,000, of which $3,000 will be appropriated to each of the five organizations, and the remaining $3,000 will be used for developing and printing the plan. Further, two representatives from each of the five groups will be appointed to establish the coalition's policies and procedures.



A framework for the West Virginia Wellness Coalition

Dr. J. N. "Joe" Jarrett Honored

The Fayette County Medical Society recently recognized retiring family practice physician J. N. "Joe" Jarrett, M.D., of Oak Hill, with a special citation for his constant and faithful service to the community and medical profession for the past 50 years. Dr. Jarrett was president of the Fayette County Medical Society twice and is a former president of the West Virginia Academy of Family Physicians. An associate editor of the *West Virginia Medical Journal,* Dr. Jarrett also is very active in church and civic activities. The citation was presented to Dr. Jarrett at a dinner held by the Fayette County Medical Auxiliary in honor of Doctor's Day.

JCAHO Approves New Standards

Two sets of new and revised standards relating to cigarette smoking and abuse victims were recently approved by the Board of Commissioners of the Joint Commission on Accreditation of Healthcare Organizations. The changes in the Accreditation Manual for Hospitals (AMH) will become effective January 1, 1992.

Standards that address hospital smoking policies will require a hospital to have a policy that "prohibits the use of smoking materials throughout the building." Any exceptions to this prohibition are to be "authorized for a patient by a physician's prescription based on medical criteria that are defined by the medical staff." Previously, hospitals were required only to have a policy that discouraged smoking. The new standards will appear in the "Management and Administration" chapter of the AMH.

Standards related to the care of patients who appear to have been abused have been expanded to include victims of spousal and elderly abuse. Current standards address only the management of child abuse and rape victims. The new and revised policies will be in the "Emergency Services" and "Hospital-Sponsored Ambulatory Care Services" chapters of the AMH.

The full text of the revisions will be published in the March/April edition of Perspectives, the Joint Commission's newsletter. For ordering information, call the Customer Service Center at (708) 916-5800 between 8 a.m. and 5 p.m., CST.

Program Provides Eye Care for the Needy Elderly

Since it opened five years ago, the West Virginia program of the National Eye Care Project has received more the 2,383 calls, and has referred more than 1,570 needy elderly to volunteer eye physicians and surgeons (ophthalmologists) within the state.

The following numbers of potentially blinding eye diseases have been diagnosed and treated in 887 patients for whom records are available: 471 cases of cataracts, 46 cases of glaucoma, 100 cases of macular degeneration, and 20 cases of diabetic retinopathy.

James A. Genin, M.D., president of the West Virginia Academy of Ophthalmology, urges all disadvantaged elderly people who need medical eye care to call the toll-free Helpline at 1-800-222-EYES.

The National Eye Care Project is sponsored by the West Virginia Academy of Ophthalmology and the Foundation of the American Academy of Ophthalmology.

Lung Association Offering Golf Cards

The American Lung Association of West Virginia is sponsoring a Golf Privilege Card which enables cardholders to complimentary greens fees at 40 state courses for more than 50 rounds of golf for $35.

Each course offers one or more free rounds, and cart rental is usually required with time restrictions applying to some courses. The card is valid through October 31 and proceeds help fight lung disease through ALAWV programs for prevention, control and cure of lung disease.

Golf privilege cards may be purchased at ALAWV offices in Morgantown, Wheeling and Charleston and at sporting goods stores throughout the state. Golf cards may be ordered over the telephone by calling the ALAWV state office at 304/342-6600 and charging the purchase to a Mastercard, Visa, or Discover card.

Kidney Research Grants Available

Baxter Healthcare Corporation of Round Lake, Ill., will be awarding approximately $1 million in new grants for kidney research worldwide in 1991. Baxter has set November 15 as the deadline for submission of Requests for Proposals (RFPs) for the sixth round of its Extramural Grant Program (EGP).

Two categories of research will be funded in this round: 1) The Preservation of Residual Renal Function and 2) The Dialysis Patient and Nutrition.

"Baxter created this grant program in response to the limited funding of basic and clinical research and in answer to the widespread diversion of research funds to AIDS," Lee Henderson, M.D., FACP, executive director of Baxter's EGP said. "Our goal is to stimulate advances in the understanding of kidney disease and to ensure that related studies are properly funded."

For more information or to forward completed grant requests, contact Lee Henderson, M.D., FACP, executive director of the Extramural Grant Program at (708) 270-5200 or at Baxter Healthcare Corporation, Renal Division,, Route 120 and Wilson Road, Round Lake, IL 60073.

WVHREF Sponsors Joint Commission Program in June

The West Virginia Hospital Research & Education Foundation is sponsoring a Joint Commission program entitled, "Advanced Medical Staff Seminar," June 7-9 at The Greenbrier.

Medical staff executive officers, medical directors, department heads, trustees, CEOs, medical staff coordinators and other medical and professional personnel directly involved in medical staff quality review functions are encouraged to attend. The cost is $495 per participant.

For more information, contact Kathy Watts, coordinator of education, WVHREF, 744-9842.

Temple University Hosts Elderfair

The many ways that science and technology are helping older Americans will be highlighted in exhibits and workshops at a four-day conference, June 15-18 in Philadelphia.

Sponsored by Temple University's Institute on Aging, the Elderfair aims to provide a technological update to physicians, social workers, nurses, rehabilitation therapists, and those who work with or market products for older people.

More than 30 workshops and plenary sessions will be featured and the participants will have the opportunity to view product demonstrations.

For more details, call Temple's Institute on Aging, (215) 787-3208.

Pathologists Set Spring Meeting

The West Virginia Association of Pathologists will hold its spring meeting May 18 at the Holiday Inn - Gateway in Barboursville.

Speakers include Dr. Antonio Amortequi from Magee Women's Hospital in Pittsburgh; Mike Palmer of the Washington, D.C. office of the CAP; and Dr. Rawhi Omar of West Virginia University. In addition, Dr. Robert Belding, WVAP president and CAP key contact, will discuss the Key Contact program. A cytology lecture by Dr. Tom Bonfiglio of the University of Rochester will also be presented from 8:30 a.m. - 9:30 a.m. for an added $35 registration fee onto the registration cost of $25.

For more information about the meeting, contact Dr. Belding at 255-2121 ext. 4292.

Stress Management Association Plans Paris Meeting

The Fourth Interdisciplinary Meeting of The International Stress Management Association (formerly the International Stress and Tension Control Association) will be held in Paris from September 1-5.

Proposals for presentations are welcomed on any scientific or applied study of stress or stress management. Some specialized topics to be featured include aging, cognitive functioning, bereavement, the cardiovascular system, psychopathology, and alcoholism.

For information, write to Professor F.J. McGuigan, Institute for Stress Management, U.S. International University, 10455 Pomerado Rd., San Diego, CA 92131.

WVU Otolaryngology Department Plans Conference

The Second Annual Alumni Conference of the WVU Otolaryngology Department will take place June 15-16 in Morgantown.

Featured speaker will be Dr. Robin Cotton, pediatric otolaryngologist from the University of Cincinnati. The program will also include resident research presentations, an endoscopic sinus surgery panel, and talks by invited guest speakers. A banquet honoring two departing senior residents and faculty members will be held on June 15.

For more details, contact Darlene Myers at 293-2479.

Continuing Education

Listed on this page are some of the upcoming continuing education programs which will be held throughout the state.

The programs this month were compiled by the following individuals: Patricia Barnhart, WVSMA loss control coordinator, Suzanne Nowell, WVU outreach coordinator of CME; Cynthia Kemp, WVU conference planner; Robin Rector, coordinator of CME for Charleston Area Medical Center; Arlene S. Feder, M.D., coordinator of Medical Grand Rounds for Ohio Valley Medical Center; and Je H. Kim, M.D., secretary of the Tug Valley Medical Association.

These programs are tentative and subject to change. Further details about these CME activities may be obtained by calling Barnhart at 925-0342; Nowell and Kemp at 293-3937; Rector at 348-9580; Feder at 234-1835; and Kim at 235-7549. Other national and state meetings are listed in the Medical Meetings Section of the *Journal.*

This schedule is presented as a convenience for physicians. If you would like to have the continuing education programs offered by your institution or association published in the *Journal,* please contact Nancy Hill, managing editor, at 925-0342.

West Virginia State Medical Association - Charleston

May 11 - WVSMA/CNA First Generation Loss Control Seminar, Wheeling

May 18 - WVSMA/CNA Third Generation Loss Control Seminar, Parkersburg

June 8 - WVSMA/CNA First Generation Loss Control Seminar, Charleston

CAMC/WVU Health Sciences Center - Charleston

May 13 - "Medical Rehabilitation Update - Bowel Training," CAMC General Division, Room 420, 12:30 p.m.

May 16-17 - "Preterm Birth Prevention: New Strategies for an Old Problem," Pipestem Resort State Park

May 11 - "Functional Endoscopic Sinus Surgery Course for the Practitioner," sponsored by WVU Department of Otolaryngology/Head and Neck Surgery and the WV Academy of Otolaryngology/Head and Neck Surgery, WVU Health Sciences Center, Room 2157, 7:30 a.m.

WVU Health Sciences Center - Morgantown

May 17 - 4th Annual Symposium of WV Network of Ethics Committees, "Making Difficult Health Care Decisions: The Role of Ethics Committees"

Ohio Valley Medical Center - Wheeling

May 8 - "Skin Signs of Internal Disease," William A. Welton, M.D., 8 a.m.

May 22 - "Epogen-alpha: Recombinant Erythropoietin Treatment of Anemia," Emil P. Paganini, M.D., 8 a.m.

May 29 - "Congenital Heart Disease," James W. Freese, M.D.

Tug Valley Medical Association - Williamson

May 15 - "Gram - Negative Infection," Tom Horsman, M.D., Western Sizzlin Steak House, Goody, KY, 6 p.m.

Outreach Programs

Key to Sponsors

★ WVU Health Sciences Center, Morgantown

☐ CAMC (*)/WVU Health Sciences Center-Charleston (△)

(Check locally for additional information)

Fairmont ★ Fairmont Clinic, May 15, "Management of Abnormal Pap Smear," Dale Joret, M.D.

Man ☐ Man Appalachian Regional Hospital, May 21, 7 p.m., "The Use and Abuse of Benzodiazepines: Atwan, Xanax, etc.," David K. Walker, M.D.

New Martinsville ★ Wetzel County Hospital, May 9, 11:30 a.m., "Office Dermatology," Rodney Kovach, M.D.

Parkersburg ★ Camden Clark Memorial Hospital

May 8, 7 a.m., "Urinary Incontinence," Dale Joret, M.D.

May 15, 7:30 a.m., "Chronic Renal Failure in Diabetes Mellitus," Elliott Chideckle, M.D.

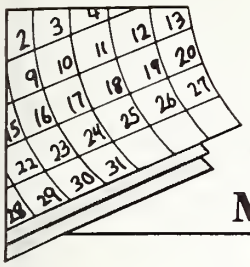
May 22, 7 a.m., "Herpes Virus Infections and AIDS in Pregnancy," Mark Gibson, M.D.

May 29, 7 a.m., Minimal Endometriosis Minimal?" Roger Toffle, M.D., Camden Clark Memorial Hospital.

Ripley ☐ Jackson General Hospital, May 10, noon, "Stage II Diabetes," Stephen Grubb, M.D.

Spencer ☐ Roane General Hospital, May 21, 12:30 p.m., "Accessing Family Resources," Anna Neale-Gerencir, Women & Children's Hospital, Family Resource Center, Charleston.

White Sulphur Springs ☐ Greenbrier Clinic, May 21, 4 p.m., "Human Papilloma Virus," John Gilbert Thomas, Ph.D.



Medical Meetings

May

16-18—American Association of Orthopaedic Medicine, Denver.
16-19—Focus on the Female Patient, Southern Medical Association, Panama City, FL.
18-22—American Gastroenterological Association, New Orleans.
19-21—American Society of Clinical Oncology, Houston.
19-22—14th Annual National Rural Health Association Conference, Seattle.
20-22—Advanced Laparoscopic Surgery, St. Vincent Hospital and Health Care Center, Indianapolis.
20-24—Fifth International Symposium on Recent Advances in Otitis Media, Ohio State University, Fort Lauderdale, FL.
29-June 3—American College of Sports Medicine, Orlando.
30-June-1—Introductory Workshop in Hypnotherapy, Menninger Clinic, Topeka, KA.

June

1—Immunologic Aspects of Liver Transplantation, Rush-Presbyterian-St. Luke's Medical Center, Chicago.
1—The Impaired Professional-Sexual Addiction: Theory and Treatment — Louisiana State Medical Society and American Society of Addiction Medicine, New Orleans.
2-5—International Society for Cardiovascular Surgery (North American Chapter) and Society for Vascular Surgery, Boston.
9-13—Fifteenth Symposium on Lung Disease, Southern Medical Association, Sea Island, GA.
11-14—Society of Nuclear Medicine, Cincinnati.
13-14—Cardiology in Practice, Ohio State University, Columbus.
19-23—1st Annual Spring Meeting, Southern Association for Geriatric Medicine, Vancouver, British Columbia.
21-23—Focus on the Chronically-Ill Patient, Southern Medical Association, Destin, FL.
24-26—8th International Congress on Group Medicine, Helsinki, Finland.

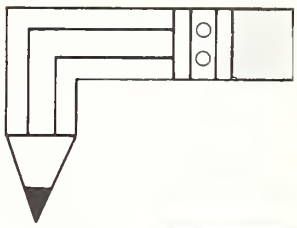
July

12-14—Vascular Research Seminar, Ohio State University, Columbus.
19-21—National Conference on Breast Cancer, American Cancer Society, Chicago.

For More Information . . .

Contact The Journal for additional information about most of the above meetings. Call (304) 925-0342.

Poetry Corner



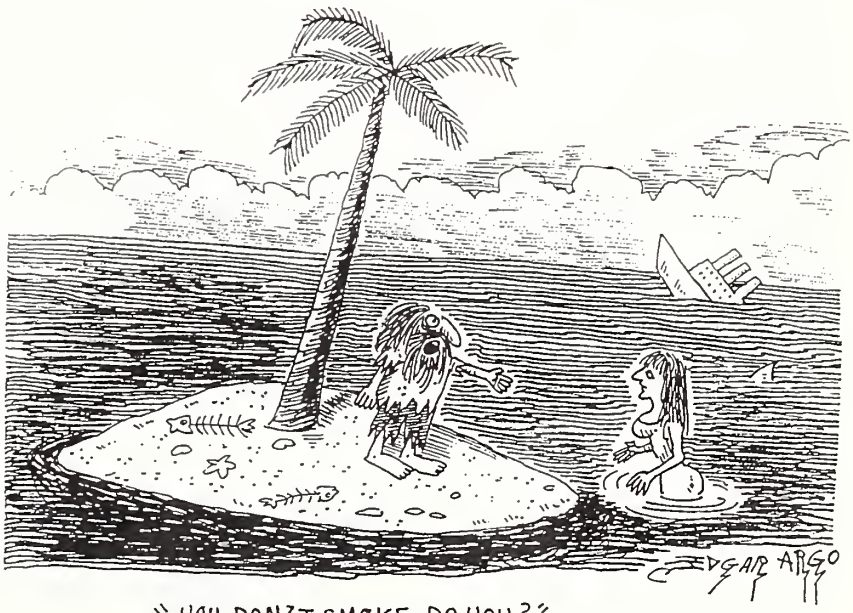
Lights in the Winter Sky

It snowed in the forest a winter day
When sky was white as snow.
The black skeletons of the trees conducted
Bright white shimmering snowlight to ground.
Like black and white neon lights, the snowflakes flashed
Like black limbs and trunks signing the sky.

It snowed in the forest a winter day
When sky was white as light
Snowflakes electrified dark limbs and impacted
The spelling bends and turns of the trees.
These standing living black bones, flowers/leaves lost,
Became black and white forest neon lights.

Lee L. Neilan, M.D.

Please address your submissions for Poetry Corner to: Stephen D. Ward, M.D., Editor, West Virginia Medical Journal, Box 4106, Charleston, WV 25364.



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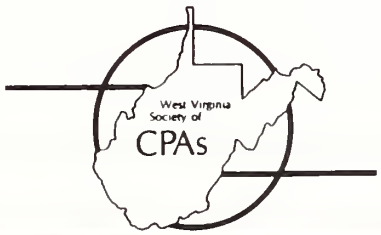

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WEST VIRGINIA UNIVERSITY HEALTH SCIENCES CENTER

Compiled from material furnished by the West Virginia University Health Sciences Center News Service, Morgantown.

Nine Research Grants Obtained

West Virginia University was recently awarded the following grants to help with medical research:

—The Department of Biochemistry has received a grant of $63,883 from the National Institute of Child Health and Human Development. The title of the study is "Regulation of Estrogen Responsive Genes." Dr. Marilyn Evans, assistant professor of biochemistry, is the study's principal investigator.

—A grant of $2,700 from the American Nurses Foundation, Inc. was awarded to the Department of Nursing to provide insight into the effects of waterbeds on heart rate in preterm infants. The principal investigator is Dr. Pamela Deiriggi, associate professor of nursing.

—The Department of Pathology is studying the amount of support of medical examiners' services with a grant of $118,999 from the West Virginia Department of Health. Dr. Winfield Morgan, acting chairman of pathology, is principal investigator.

—The Department of Dentistry has received a grant for $65,533 to continue a five-year study entitled "The Periplasmic Flagella of Treponema Denticola." Dr. John Ruby, principal investigator, is a graduate student in microbiology and adjunct assistant professor of dentistry.

—The Charleston Division of the WVU Health Sciences Center obtained a grant of $47,475 from the Bureau of Health Professions for a project entitled "A Quality Assurance and Risk Management Training Program." Dr. William O. McMillan is the study's principal investigator.

—The Department of Pharmacology and Toxicology has received a grant for $20,000 from the Eli Lilly Corporation for a study entitled "Protein Kinase C & Androgen Dependent Smooth Muscle Proliferation." Dr. Michael Mawhinney, the principal investigator, is a professor of pharmacology and toxicology, and of urology.

—The Department of Endocrinology obtained a grant of $15,000 from Sandoz Pharmaceuticals to investigate the amount of low blood pressure in the treatment of autonomic neuropathy with the drug octreotide. Dr. Robert Hoeldtke, professor of medicine and chief of endocrinology, is the principal investigator.

—The Department of Endocrinology was awarded a grant of $87,934 from the National Institute of Health to investigate salt-induced hypertension developed by the resistance of microscopic blood vessels to blood flow. Principal investigator is Dr. Matthew Boegehold, an assistant professor of endocrincology and physiology.

—The USDA Forest Service has given the Department of Biochemistry a grant of $53,732 to identify the behavior and effects of the pesticide, dimilin, which is used to slow the spread of the gypsy moth to West Virginia from the Northeast. Dr Mary Wimmer, associate professor of biochemistry, is the principal investigator.

Cancer Study Fellowships Honor Lewisburg Man

University undergraduates will be able to participate in basic science research at the Mary Babb Randolph Cancer Center each summer under a new fellowship program.

The Edwin C. "Spud" Spurlock Summer Research Fellows will each spend 12 weeks working directly with Cancer Center basic sciences faculty on projects designed to determine the causes and best treatment of human cancer.

Spurlock, who operates Spud's Barbecue in Lewisburg, distributes products nationwide from his Greenbrier County business.

The fellowship program was announced at the 1991 "Building the Best" Mary Babb Randolph Cancer Center Gala, held at The Greenbrier on April 5 and 6.

Dr. Tom Dotson of The Greenbrier Clinic and Lawson Hamilton of Lewisburg presented Spurlock with an award naming him "Inspirational Patient of the Year."

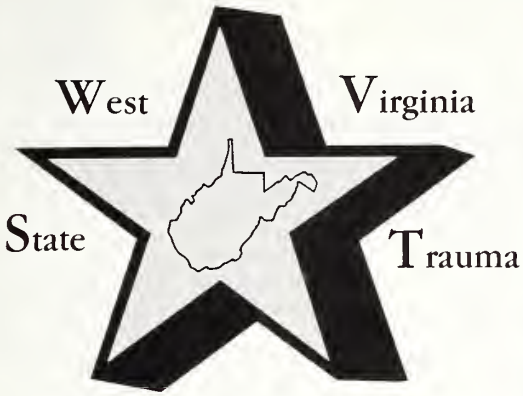
The gala, an annual fundraiser for the Cancer Center, featured TV chef Julia Child and attracted a large number of Cancer Center supporters. The event raised about $200,000 for cancer research and treatment, according to Denver Allen, the Cancer Center's director of development.

Ponte Named to USP Advisory Panel

Charles D. Ponte, professor of clinical pharmacy and family medicine at West Virginia University, has been named to a national advisory panel on drug standards and information.

Dr. Ponte will assist the United States Pharmacopeial Convention (USP), the official national agency for setting pharmaeutical standards, in determining the content of the USP DI data base. The data base provides information for health care providers and consumers, and offers input on drug standards and information.

Dr. Ponte will serve until 1995 on the USP's family practice advisory panel.



June 29, 1991
Olgebay Park
Wheeling, WV

Program Agenda

8:00 a.m.	Registration, Continental Breakfast
8:30 a.m.	Introduction
8:45 a.m.	St. Mary's Case Presentation
9:30 a.m.	Cabell-Huntington Case Presentation
10:15 a.m.	Break
10:30 a.m.	West Virginia University Case Presentation
11:15 a.m.	Charleston Area Medical Center Case Presentation
Noon	Lunch (Provided)
1:00 p.m.	Wheeling Hospital Case Presentation
1:45 p.m.	Ohio Valley Medical Center Case Presentation
2:30 p.m.	Break
2:45 p.m.	State Research Project Report: Hypothermia
3:30 p.m.	Discussion/Questions & Answers
3:45 p.m.	Evaluation/Adjourn

For registration information contact:

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Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

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Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

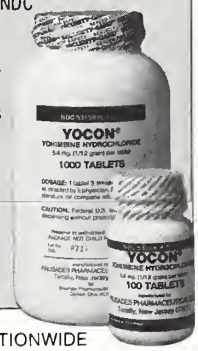
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85



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MU School Of Medicine News

MARSHALL UNIVERSITY

Compiled from material furnished by the Office of University Relations, Marshall University

New Equipment Enhances Pathology

Pathologists at the Marshall University School of Medicine now have at their disposal state-of-the-art equipment for analyzing patients' diseased cells.

The two new tools, a flow cytometer and an image analyzer, are both worth about $100,000 each and are located at the VA Medical Center in Huntington. Both instruments help doctors to diagnose and monitor treatment of such diseases as AIDS, mononucleosis, herpes, and leukemia, according to Dr. Richard J. Baltaro, assistant professor of pathology at the MU School of Medicine.

In addition to its role in patient care, the new equipment is also a valuable learning and research tool, Dr. Baltaro said. Residents, medical and graduate students, and faculty now have an opportunity to work with some of the most advanced instruments available in the field of immunopathology. The image analyzer allows pathologists to view a laboratory slide on a video screen and study groups of cells, while the flow cytometer is an extremely fast, accurate and highly sensitive instrument for examining certain characteristics of single cells.

Dr. Baltaro explained that by analyzing blood cells, the flow cytometer can measure the different components involved in the immune response to a disease. Knowing which components are present and in what amounts, doctors are better able to diagnose and treat AIDS. For example, a certain type of "helper" blood cell, the T-lymphocyte, is severely diminished in AIDS. Counting the number of T-cells is increasingly important in the treatment of AIDS.

"We now have drugs that may help us," Dr. Baltaro said. "If we give these drugs and see that the T-lymphocytes are no longer being killed, we know that the drugs are working. Without readings from the flow cytometer, doctors would have no objective way of knowing how effective a particular drug is."

Improved diagnosis and monitoring of certain cancers is also possible because of the two instruments' ability to measure the amount of DNA in cells and to indicate the number and size of cells going through the growth cycle. Most cancer cells have abnormal amounts of DNA and grow faster, requiring more aggressive treatment.

According to Dr. Baltaro, the VA Medical Center's image analyzer is the only one in West Virginia and the flow cytometer is the most advanced in the state. Originally used in research, the instruments have only recently been put to clinical use.

Three Projects Receive Awards at Research Day

Three research projects by medical students, residents and faculty were singled out for honors at the Marshall University School of Medicine's Fourth Annual Research Day.

The program, held April 9 at the Holiday Inn-Gateway in Barboursville, featured 52 presentations describing the work of 111 researchers. Project categories were basic science, clinical science, and clinical case studies. Prize winners received a plaque and a cash award.

Thais P. Salazar, a Ph.D. candidate in microbiology from Grafton, won the award for best basic science presentation. Her project was entitled "Characterization of Genes Determining Herpes Simplex Virus Type-1 Ocular Disease Patterns." It was co-authored by Dr. Terry W. Fenger, associate professor of microbiology.

Jaime Hernadez, M.D., a resident who holds a fellowship in infectious diseases, won the prize for best clinical case study. Dr. Hernadez's project was "Successful Treatment of Post-Traumatic Candida Myocarditis with Surgery and Amphotericin B Followed by Long-Term Suppression Therapy with Fluconazole." Co-authors were Dr. Haytham Jabi, assistant professor of medicine, and Dr. Lorenzo Gonzales-Lavin, professor of surgery. Glaxo, Inc., a pharmaceutical company, sponsored the clinical case study award.

Cynthia Gonzalez, M.D., a resident with a fellowship in pulmonary medicine, won the Dr. Lester R. Bryant Research Award for Clinical Science. Her project was titled "An Evaluation of PImax and PEmax as Predictors of Postoperative Pulmonary Complications." Co-authors were Dr. Kuldeep Pandit, associate professor of medicine; Dr. Nancy Munn, associate professor of medicine; Dr. Manoj Majmudar, formerly at MU under a pulmonary medicine fellowship; and Henry K. Driscoll, assistant professor of medicine.

Surgeon to Moderate International Session

Dr. Lorenzo Gonzalez-Lavin, professor of surgery, will moderate a session on vascular bioprostheses at the Fifth International Symposium for Cardiac Bioprostheses, May 24-27 in Avignon, France.

Dr. Gonzalez-Lavin, head of Marshall's division of cardio-thoracic surgery, is one of only four U.S. physicians serving on the 12-member scientific committee for the meeting. Sarah Noeker, RN, MU cardiac surgical nurse coordinator, also will attend the conference.

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Obituaries

JOHN McCLURE GRUBB, M.D.

Dr. John McClure Grubb, 69, a well-known Point Pleasant physician and cancer crusader, died February 19 at Charleston Area Medical Center, following a long illness.

Dr. Grubb attended Butler University School of Law, pre-med at West Virginia Wesleyan College, and the Medical College of Virginia. He interned at CAMC - Memorial Division and relocated his practice to Point Pleasant in 1964.

For 23 years, Dr. Grubb served as Mason County coroner and he was named National Volunteer of the Year for the American Cancer Society in 1985. He was a past president of the West Virginia and Mason County Cancer Societies.

Dr. Grubb was a member of the Minturn Lodge #19 AF&AM, the Beni Kedem Shrine, the Scottish Rite and the Knight's Templar. He was a team physician for the Point Pleasant High School Athletic Department for 25 years, a staff member of Pleasant Valley Hospital for 27 years and was an Air Force veteran of World War II.

Survivors include his mother, Ester (McClure) Grubb of Charleston; his wife, Shirley (Simpson) Grubb of Point Pleasant; two daughters, Roberta L. Corrie of South Charleston and Mary E. Hudson of San Antonio, TX; two sons, John M. Grubb II of Phoenix, AZ, and George M. Grubb of Point Pleasant; one brother, Dr. George Grubb of Charleston; two sisters, Jane Warner of Charleston and Harriett Blair of Parkersburg, and eight grandchildren.

D. H. LOUGH, M.D.

Dr. D. H. Lough, 79, of Clarksburg, died February 24 at home following an extended illness.

Born in Morgantown, Dr. Lough attended the West Virginia University School of Medicine and graduated from Northwestern University School of Medicine in Chicago in 1937. He served an internship at Mercy Hospital in Pittsburgh from 1937-38 and participated in a number of postgraduate courses.

After being licensed in West Virginia in 1938, he opened an office in Clarksburg to practice his specialities of family practice and general surgery. He was elected to membership in the Harrison County Medical Society in 1939 and served that organization as vice president in 1951 and as president in 1953. He was a member of the West Virginia State Medical Association and the Southern Medical Association.

A Charter Fellow of the American Academy of Family Physicians, Dr. Lough was a member of the West Virginia Chapter of the American Academy of Family Physicians. He served as president in 1947 and secretary in 1952 of the medical and dental staff of the former Saint Mary's Hospital and as president in 1960 of the former Union Protestant Hospital medical and dental staff. In 1970 and 1971, he served as chief of staff of United Hospital Center in Clarksburg.

A member of the board of directors of the Harrison County United Fund, now the United Way of Harrison County, Dr. Lough was a Paul Harris Fellow. He was also a member of the board of directors and chairman of the Crippled Children's Committee of the Clarksburg Rotary Club.

Surviving are four daughters, Judith Ann Bell, Columbia, Md., Mary Sandra Limbers, Wilmington, Del., Sharon L. Pettrey and Donna L. Dyer, both of Clarksburg, and one son, Dr. Donald H. Lough Jr., Wheeling; 15 grandchildren; five great-grandchildren; two brothers, Harold Lough and William Lough and two sisters, Mrs. Beatrice Sproat and Mrs. Dorothy Jones, all of Morgantown; several nieces and nephews.

ALFREDO R. SOLIVA, M.D.

Dr. Alfredo R. Soliva, 51, a native of the Philipines who practiced medicine and operated a medical clinic in Williamson for the past two decades, died on December 3 in Cleveland Clinic.

Dr. Soliva, who maintained medical offices in the Cinderella Building in Williamson, died of heart failure. He was past chief of the medical staff at Williamson Memorial Hospital and former chairman of its Department of Medicine. He had served on every committee in the hospital in past years and at the time of his death was chairman of the Infection Control and Quality Assurance Committee.

From 1981-83, Dr. Soliva headed the medical staff at Williamson Appalachian Regional Hospital. At one time he owned and operated the Salton Medical Clinic as well as the Soliva Medical Clinic.

Dr. Soliva graduated magna cum laude from Central Philipine University in the Philipines in 1958 and earned his medical degree from Far Eastern University in 1963. He interned for a year in the Philipines and came to the U.S. the following year and did a one-year rotating internship at Saint Joseph's Hospital in Patterson, N.J. After completing a two-year residency at Saint Joseph's, he went to New York City for his third-year medical residency at Metropolitan Hospital.

Before coming to Williamson 20 years ago, Dr. Soliva practiced in Welch. He was a member of the American Medical Association, the American College of Physicians, the American Society of Internal Medicine, the West Virginia Medical Association and the Mingo County Medical Association.

Survivors include his mother, Ursula Soliva, sister, Genra Maglaya, brother, Ernesto Soliva, all of the Philipines; two other brothers, Roger Soliva of Newbury, Conn., and Dr. Domingo Soliva of The Bronx, New York; nephew, Martin Maglaya of Williamson.

County Society

McDowell

The McDowell County Medical Society's April 10 meeting featured a video on emergency medicine entitled "Diagnosis and Management of Soft Tissue Infections."

The letter from the WVSMA concerning the physician award and presidential citation was discussed under new business. The members also voted to get permission to place the "Weekly Headlines" mailings sent by the WVSMA in the Welch Emergency Hospital Library.

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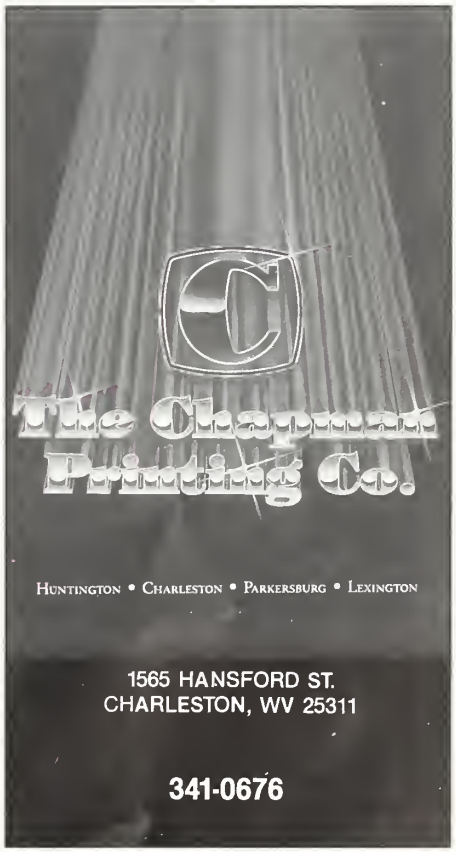

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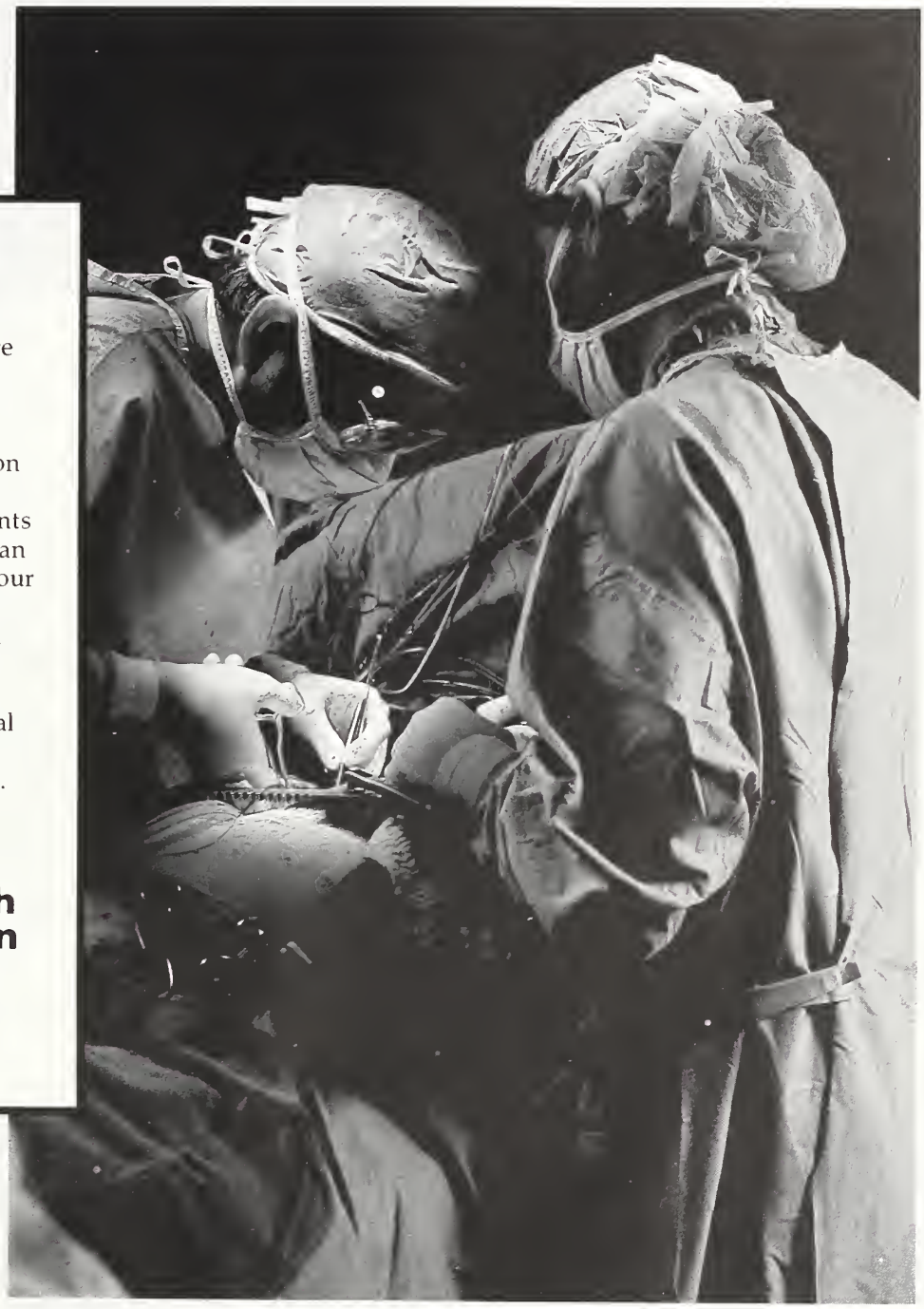

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Front Cover

Seneca Rock, Randolph County. Photo courtesy *Stephen J. Shaluta Jr., West Virginia Department of Commerce.*

It's Those Doctors, Not My Doctor

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Executive Director, West Virginia State Medical Association, Charleston

The medical profession has been singled out by the media and others as the root cause of increases in health care costs. This has resulted in an apparent diminution of the respect that physicians and their profession have always received from our society.

Why has this happened? Is there a real basis for this apparent loss of prestige and admiration so long enjoyed by the profession?

The answer to that question is very difficult to quantify. Antidotal episodes used so effectively by the media and others certainly give the impression to the general public that today's physicians are suspect in their motivations for choosing medicine as a career.

Unfortunately, attempts to respond to these attacks on the integrity of the profession are done through the same media that created the issue. As a result, the attempts at defending themselves and their profession are usually interpreted as self-serving cries by someone caught with their hand in the cookie jar.

It must be said at this point that there are problems within the profession. As human beings, physicians are subject to the same frailties of all people. Thank goodness very few of them succumb to these temptations. Those who do are easily identified because these transgressors stand out so obviously from their peers. However, their actions appear to some as the norm for the profession rather than the rare exceptions.

For example, a book titled *"6,892 Questionable Doctors"* written by Sidney Wolfe, M.D., an associate of Ralph Nader, identified individuals who had disciplinary actions taken against them by state medical licensing boards throughout the country. The author of this treatise was seen on national news and talk shows and as a physician, his comments were given stature greater than was deserved. In addition, not all of the individuals exposed in the book were physicians, and many had actions taken against them that were unrelated to the quality of their medical practice. The 6,892 figure, in and of itself, may be impressive but as a percentage of all practicing U.S. physicians, it is just over one percent.

What then is the perception of the medical profession by U.S. and West Virginia citizens? It appears that it depends on how the questions are asked. The WVSMA has obtained survey results from four sources to find out how people feel about physicians and medical services in general.

The first survey, which required written responses, was conducted in October/November 1989 by the West Virginia Department of Health and Human Resources and directed to 5,000 Medicaid beneficiaries. Although they gave no specific reason for the assumption, the Department of Health and Human Resources felt that the survey was, in some way invalid, and it was never made public. The results obtained from the 2,343 responses received are as follows: (Comments by the analyst who compiled the report appear in italics after each question.)

1. Do you have a regular family doctor?

Yes 74%

"The only surprising finding on this particular item is the fact that 73.71 percent of those responding to the survey indicate that they do have a regular family physician."

2. A. Do you have to wait a long time to get an appointment?

83% said they never or only sometimes have to wait a long time.

B. Do you spend a long time in the waiting room before you're seen by anyone?

80% said they never or only sometimes have a long wait in the doctor's office.

C. Are you treated with respect at your doctor's office or clinic?

91% said they are always or sometimes treated with respect.

"In general, the respondents to this question do not perceive themselves to be treated differently, disrespectfully or discriminated against in medical services."

3. The last time you needed to see a specialist were you referred without delay or problem?

Of the 66% who responded, 88% said they had no problem with referrals.

"In general, this finding would indicate that Medicaid-eligible recipients have access to medical specialists' services at a level which is probably equivalent to that of private pay patients."

4. How often have you been refused medical care?

92% said they had never, or not very often, been refused medical care.

"The responses to this item on the survey indicate that Medicaid recipients do indeed have access to medical care to a much greater extent than would have been expected."

The second study was done by Ryan/Samples Research, Inc. in April 1990 for Atlantic Financial Savings and Loan, the *State Journal* and West Virginia Public Radio. In this survey, 397 adult heads of household were contacted randomly by phone and the following results were obtained:

1. Have you ever had a problem finding a doctor in your community?

No	**78%**
Yes	**21%**
DK/NA	**1%**

2. Do you presently have a family physician or other health care provider, that is one you visit for checkups and health care problems?

Yes	**83%**
No	**17%**

3. Is that person a medical doctor, osteopath, physician assistant, nurse practitioner, other?

M.D.	**90%**
D.O.	**3%**
Nurse Practitioner	**2%**
Physician Assistant	**1%**
Other	**3%**
DK/NA	**1%**

The Gallup organization conducted the next two polls which were done simultaneously in January 1991. One was carried out on a national basis for the AMA and the other was directed at West Virginia citizens for the WVSMA. The results from the AMA's poll of 1,500 adults is shown in Table 1 and the responses derived from the 400 participants in the WVSMA's poll are found in Table. 2

The results of the Gallup surveys indicate that people have two perceptions of physicians. When participants were asked questions about physicians in general, their responses were negative, but when questioned about their personal physician, the answers were positive (Tables 1 and 2).

Table 1.

Evaluation of the Medical Profession (National Poll)
A. 38% think doctors act like they're better than other people.
B. 69% say that people are losing faith in doctors.
C. 58% do not think doctors usually explain things well.
D. 63% say doctors are too interested in making money.
E. 69% do not think doctors spend enough time with their patients.
Evaluation of the Personal Physician (National Poll)
A. 91% were very satisfied, or somewhat satisfied, with the medical care they received.
B. 94% were very satisfied, or somewhat satisfied, with the way the doctor's staff treated them.
C. 89% were very satisfied, or somewhat satisfied, with the way the doctor explained things.
D. 82% were very satisfied, or somewhat satisfied, with the amount of time they had to wait to get an appointment.
E. 78% were very satisfied, or somewhat satisfied, with the amount of time they had to wait before seeing a doctor.
F. 75% were very satisfied, or somewhat satisfied, with the fee the doctor charged.

Table 2.

Evaluation of the Medical Profession (State Poll)	**Evaluation of the Personal Physician (State Poll)**
A. 62% said doctors do not explain things well.	A. 84% said their doctor explains things well.
B. 67% said doctors do not spend enough time with them.	B. 80% said their doctor spends enough time with them.
C. 68% said doctors are too interested in making money.	C. 20% said their doctor is too interested in making money.
D. 74% said people are losing faith in doctors.	D. 12% said they are beginning to lose faith in their doctor.
E. 39% said doctors act like they're better than others.	E. 8% said their doctor acts like he/she is better than others.

I believe that, as this article is titled, people see the medical profession on two planes. One is abstract, the other personal. The dichotomies between these two perspectives are obvious. The questions addressed in this article from the four surveys, show that the physician/patient relationship is very positive. Entities outside the profession are making assumptions about the quantity and quality of physician services that are not shared by patients but accepted by the general public.

These surveys also strongly show that the individual physician holds the key to maintaining the admiration and respect of society for the profession. Physicians must be supportive of their peers and make that known to their patients. Physicians must take the time to discuss issues as outlined in the WVSMA "White Paper 1991" with their patients. Only through one-on-one dialogue can patients be made aware of these misconceptions about the medical profession.

When patients respond to inquiries about health care, make sure they are speaking from personal experience and not perceptions they develop based on what they hear from others.

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Contact Nd:YAG Laser for Soft Tissue Surgery

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Abstract

Soft-tissue surgery of the head and neck entails precision, facility, hemostasis and prompt repair. The **SLT** contact Nd:YAG laser system was used on 300 head and neck soft-tissue cases. Its advantages are clean dissection, and a lesser degree of bleeding, tissue trauma, edema, seroma formation, granulation tissue reaction, pain and scarring. This paper describes the versatile application of the **SLT** contact Nd:YAG laser for successful soft-tissue surgery.

Introduction

Development of the contact Nd:YAG laser system by Daikuzono (1) in 1985 ushered in a versatile and effective tool for soft-tissue surgery. Its tissue effect is determined by direct application of synthetic sapphire probes to tissues at a desired power setting. Consequently, the contact Nd:YAG laser system is capable of coagulating, cutting, vaporizing and debulking tissues (2). It has both transcavitary and external surgical applications. Since it is delivered through fiberoptics, it has added application in endoscopic surgery. Tissue penetration is 0.5 mm at 15 watts, continuous wave in contrast to the scattering effect and pigmented tissue affinity in the non-contact mode. With a wavelength of 1064 nm, it is effective in a fluid-filled environment as distinguished from the CO2 laser. This paper reports the effective use of the SurgicalLaser Technologies (**SLT**) contact Nd:YAG laser system in head and neck soft-tissue surgery.

Materials and Methods

Between 1988 and 1990, 300 patients underwent soft-tissue surgery of the head and neck using the Surgical Laser Technologies (**SLT**) contact Nd:YAG laser at the Eye and Ear Clinic of Charleston and the Charleston Area Medical Center. Laryngeal and intraoral cases are excluded in this report. The various soft tissue procedures are listed in Table 1.

TABLE 1.
CASES
1988-1990
(24 months)
excludes intraoral & laryngeal cases

Excision skin lesions (Basal cell carcinoma, hemangioma, squamous cell carcinoma, keratosis)	120
Excision carcinoma lips	6
Excision submaxillary gland	22
Excision parotid gland	20
Excision thyroid gland	25
Neck dissection	40
Miscellaneous (Tracheoplasty, cysts, debridement, flaps, myotomy)	50

Patients' ages ranged from 1 to 90 years and 80 percent of these cases were done under general endotracheal anesthesia. Commonly, the power setting was at 13-15 watts continuous mode for cutting using a 0.6 mm - 0.8 mm frosted sapphire scalpel and at 8-10 watts continuous mode for vaporizing and coagulating using a round probe. Control of bleeding for blood vessels over 2 mm in diameter is achieved by siding, that is applying the side of the scalpel to both sides of the blood vessel before transection; ligation, monopolar electro-cautery and hypotension anesthesia.

To prevent inadvertent retinal injury due to accidental fiberoptic breakage or leakage, surgeons and operating room personnel are required to wear YAG laser protective glasses (optical density of 5 or higher) (3). Patient's eyes are protected with wet double eyepads. Since the contact YAG laser cannot be deflected in contrast to non-contact laser, a laser endotracheal tube is not required for head and neck soft tissue surgery.

The average blood loss for patients with radical neck dissection is 50 cc and 10 cc for parotidectomy and

Table 2.
Contact YAG Laser Related Complications

2 Spinal accessory nerve paralysis	Resolved in 8 weeks
1 Facial nerve trunk paralysis	Resolved in 12 weeks
3 Facial nerve branch paralysis	Resolved in 8 weeks
2 Recurrent nerve paralysis	Resolved in 8 weeks
2 Flap dehiscence	1 skin grafted 1 epithelialized
1 Orbital cellulitis (post basal cell ca excision, cheek	Drained, antibiotics Resolved in one week
2 Immediate postoperative bleeders	Explored & controlled
1 Salivary fistula (post parotidectomy)	Resolved in four days after exploration & pressure dressing

thyroidectomy. All these patients were kept overnight and discharged with removal of their drainage tubes.
Other patients were discharged on the same day of their surgery. Postoperative medications consisted of mild analgesics and broad spectrum antibiotics. Oral feedings were resumed when these patients were fully reactive.

Complications related to the use of the Contact Nd:YAG laser are listed in Table 2. Temporary paralysis of facial, recurrent and spinal accessory nerves were attributed to the heat generated at 15 w continuous wave from the side of the frosted sapphire scalpel during dissection. Complete recovery from paralysis occurred in 8-12 weeks. Paralysis had not been observed after the power setting was reduced to 13 w continuous wave. There was one instance of a post parotidectomy salivary fistula that was persistent for two weeks. This was explored, sealed with absorbable collagen pads and pressure dressing was applied. The salivary leak resolved in four days. Gustatory sweating was not evident in any of the parotidectomy cases.

Case Illustration

A 75-year-old white man was examined for a protruding lesion on the right cheek and an ulcerative lesion on the left parotid area. Both lesions were noted for 30 years and both had enlarged in the previous nine months. The protruding lesion on the right cheek measured 15 cm in length with a 6 cm base (Figure 1). The ulcerative lesion on the parotid area measured 5 cm with infiltration of the parotid tissue. The facial nerve was not paralyzed. The patient is a recluse and smokes a pipe. He decided to seek medical attention when he could no longer get a fork to his mouth because of the protruding cheek tumor and he was also having difficulty resting his head due to the ulcerative parotid lesion. The patient was alert, well-developed, well-nourished and ambulatory.

CT scanning showed a mass arising from the right cheek without bone destruction (Figure 2). Chest x-ray was normal. The regional nodes were not palpable and non-evident on CT scan.

Under general endotracheal anesthesia, an **SLT** contact Nd:YAG laser was used to resect the cheek tumor to the periosteum and a 5 mm layer of maxillary bone was excised with a chisel. The defect (Figure 3) was repaired with double cheek-neck rotational flaps and closed in two layers over a Penrose drain (Figure 4). The lateral lobe of the parotid gland was at the same time laser resected with the ulcerative lesion and cuff of skin. The facial nerve was preserved and

Figure 1. Protruding squamous cell carcinoma of cheek skin and subcutaneous tissue.

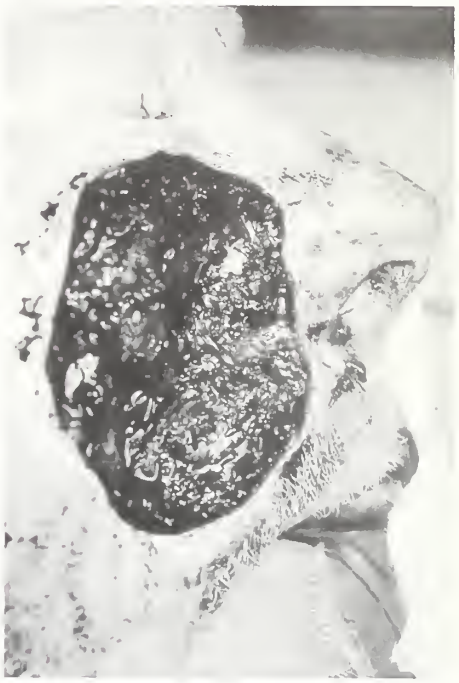

Figure 3. Post laser resected surgical defect.

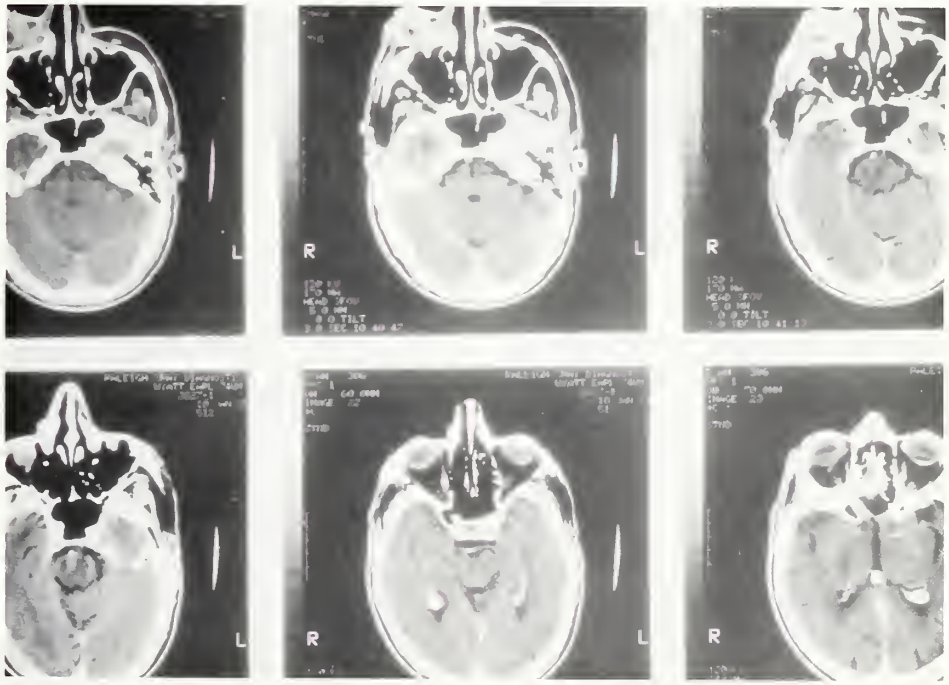

Figure 2. CT scan showing absence of bone penetration.

the surgical defect was reconstructed using a pectoralis major myocutaneous flap.

Postoperative Course

After removal of the Penrose drains, the patient was discharged the day after surgery. Both specimens were diagnosed as squamous cell carcinoma (Figure 5) with pseudosarcomatous changes at the base of the protruding cheek tumor. His cheek healed well with hardly a scar in one month (Figure 6). Four months postoperatively, he underwenta contact YAG laser left radical neck dissection for regional node metastasis. He had postoperative cobalt treatment to the right cheek, left parotid area and both necks. He was followed for one year without evidence of recurrence, but died from complications of pneumonia unrelated to his primary cancer.

Figure 4. Repair of defect with double cheek-neck rotation flaps.

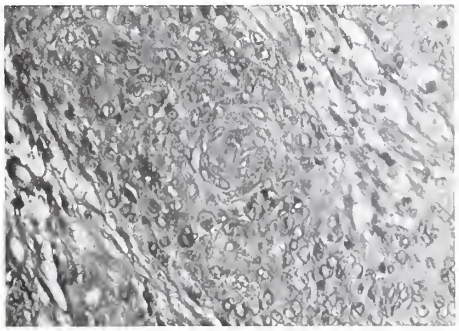

Figure 5. Histological diagnosis of squamous cell carcinoma (200x H&E).

Discussion

The **SLT** laser system consists of a console, fiberoptic cords, handles and probes. A 30 or 60 watt console is portable, easy to install (220 v outlet), easy to maintain, relatively inexpensive, and versatile for many specialties. The **SLT** laser system can be used both for contact and non-contact modes. Its advantages are namely facility, hemostasis, precision, atraumaticity, acicatrization, a short hospitalization and cost-effectiveness. Its main drawbacks are that it cannot cut bone and cannot coax with the operating microscope. It should not be used for skin incision, especially for scar-prone patients. To avoid probe breakage and to facilitate tissue effect, probes should not be pressed or buried in tissues but applied with light strokes only during the operation. In contrast to electrocautery, the contact Nd:YAG laser is precise, creates less tissue trauma, and there is absence of subdermal bleeding and tissue jerking, but more heat is generated (1,000 celsus).

The YAG laser, through development of contact tips (4) such as synthetic sapphire probes, diffusers and scalpels, is the only laser that can be utilized in direct contact with tissue. Through these contact tips, laser energy is concentrated to a definite area producing precise incision with hemostatic action. They are used in direct contact with tissue which allows controlled manipulation and restores the tactile feedback that is not possible in other laser technique (5). Sapphire scalpels create a localized region of high-power density at the tip of the probe that is applied directly to the target tissue. Since there is concentrated laser energy at the tip, focusing is not required.

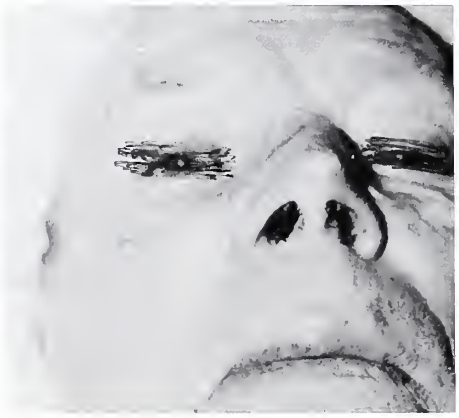

Figure 6. Postoperative results one month after.

The contact YAG laser is not limited by its absorption spectrum to any specific tissue. It is transmitted through fiberoptics with minimal power loss. Blood loss studies with sapphire scalpels show significantly less bleeding and the capability to provide cutting and coagulation. Less smoke is generated by the contact scalpels in distinction to the non-contact method. Contact YAG laser when applied on the skin produces a 1 mm thermal necrosis that must be excised prior to closure to prevent dehiscence and hypertrophic scar. Contact sapphire scalpels are utilized with a standard YAG laser which produces light in the near infrared spectrum at 1064 nm. Hukki et al (6) demonstrated that for a 0.2 mm scalpel, the tissue penetration is 0.07 mm and 0.3 mm in pigskin and 0.07 mm-0.3 mm in subcutaneous fat.

Contact YAG laser resection has enhanced the surgeon's ability to perform various soft-tissue surgery in the head and neck. Its ability to cut and coagulate simultaneously avoids blood replacement in most cases and affords the surgeon a dry field to dissect precisely and speedily pathological tissues, and to delineate and preserve efficiently vital structures. General principles of hemostasis with identification and control of afferent vessels and traction and countertraction during dissection must be observed (7).

Summary

The contact Nd:YAG laser is an effective tool for head and neck soft tissue surgery for its precision, predictability, and touch technique. Understanding of its biophysics, precaution and application expedites operation, enhances surgical results and shortens hospitalization.

Acknowledgements

The authors wish to thank the laser teams at Eye and Ear Clinic and CAMC, and Mario Plata, M.D., for providing the histological diagnosis.

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Salmonella D Enteritis in the Newborn: A Maternal Infant Case Study

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Abstract

This is a case of a 31-year-old pregnant female who had diarrhea one week prior to delivery and was later diagnosed as having Salmonella D. This report also discusses the physical changes in the neonate within 48 hours post delivery and medical treatment for Salmonella D.

Case Report

On August 13, 1990, a 31-year-old white gravida 4, term 2, abortion 1, living 2, delivered a full-term female infant vaginally, weight 6 pounds, 4 ounces. Clinical examination of the infant was normal. Thirty-six hours after birth, tachypnea of 60 to 70 B.P.M. was noted. The planned discharge was delayed for a few hours. The tachypnea persisted and cyanosis was noted. Septic work-up was initiated.

Results of chest and abdominal x-rays were normal. Spinal tap was negative. WBC was 10,900 with 16 percent lymphs, 16 percent mono, 21 segs, and 47 percent bands. Repeat WBC in six days was 15,300 WBC's with 50 percent lymphs, 11 percent monos, 33 percent segs, and no bands. Platelets were normal throughout. Prophylactic antibiotics ampicillin and gentamicin were ordered for possible septicemia.

Blood and urine cultures were negative. Stool culture was positive for Salmonella species group D. Since this organism is rare in neonates, the infectious disease consultant was contacted and he suggested that the antibiotics be changed to Claforan 140 mg. q 12 hours x 10 days IV.

The infant was discharged 10 days later and cultures done the day of discharge were negative. The patient was seen in the clinic in two weeks later. The stool cultures were positive for Salmonella since it is common for stools to be positive for weeks or even months after treatment with antibiotics.

Discussion

Salmonella has three species recognized today. S. enteritidis, S. cholerae suis, and S. typhi. S enteritidis has some 2,200 serotypes noted while S. choleraesis and S. typhi have no subtypes (1).

In the United States, estimates of people contracting Salmonella per year is over 2,000,000 cases. There are six major routes of infection for transmission of Salmonellosis to individuals:

1. Fecal-oral transmission usually during labor or delivery,
2. Contamination by infected persons,
3. Transfer of organisms from infant to infant on the hands of nursery personnel,
4. Fomites,
5. airborne infection, and
6. foodborne infection (2).

"In addition, during the newborn period, Remington and Klein note, "the high average gastric PH combined with the buffering action of frequent milk feedings and a relatively rapid gastric emptying time favor infection with ingested Salmonella organisms" (2).

Once the organism infects the host, the onset of symptoms is usually abrupt, starting with loose stools which may or may not be accompanied by vomiting. If the disease develops slowly in the infant, lethargy and a decrease in appetite and weight will be present for several days before clinical gastroenteritis is noted.

In an acute stage of Salmonella enteritis, positive stool cultures will be seen up to two weeks post infection in 70 percent of infected individuals. At four weeks, positive stool cultures are found in 50 percent of infected individuals and at 10 weeks, positive stool cultures are reported in 10 percent to 25 percent of infected individuals (2).

The mortality rate of Salmonella may be as high as 20 percent; however, this is considered low when compared to mortality of other gram negative organisms (3).

Resistant Strains

There has been concern that the use of antibiotics in animal feed might lead to antibiotic resistant organisms in animals and that these organisms or their R factors could

*This article was written when Dr. Hill was the chief of Pediatrics at Ohio Valley Medical Center in Wheeling.

be transferred to human hosts (4). In a study by the Public Health Laboratory, they found that some animal food contained antibiotic-resistant coliforms and that these coliforms could transfer their resistance to other organisms (5).

When antibiotics are given concurrently as growth supplement, any antibiotic-sensitive strain remaining might be eliminated and the resistant organisms increase proportionately (5). Indications in the 1980s have shown that farmers using antibiotic-containing feeds in animals such as poultry, beef, pork, and egg products are producing Salmonella resistant to ampicillin and chloramphenicol (2). It has been stated that up to 50 percent of poultry, 5 percent of beef, 16 percent of pork and 40 percent of frozen egg products purchased in retail stores contain Salmonella (2).

Treatment

In adults, studies have shown that antibiotic therapy only prolongs the excretion of Salmonella. This promotes the emergence of resistant strains and therefore hampers the use of antibiotic therapy in a systemic infection (6).

Infants three months of age or younger, children with immunologic deficiency or who suffer from a severe and protracted course of Salmonella, are at high risk and should be given a third-generation cepholosporin such as Claforan. (5)

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Medical Grand Rounds

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Edited by Irma H. Ullrich, M.D., Professor of Medicine

The Role of the FDA in New Drug Development and Availability

Discussant:
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Editor's Note: *Dr. Murgo was on the faculty at the West Virginia University Health Sciences Center in the Hematology/Oncology section from 1983 until 1989 when he joined the FDA.*

Abstract

During the last decade, the process by which the FDA regulates investigational new drugs has become a renewed focus of national attention. The ability of the FDA to maintain a balance between accelerating the availability of new drugs and ensuring that patients do not receive unsafe or ineffective treatments has been particularly challenged by the AIDS crisis. In response to this crisis, the FDA has revised its regulations and created various formal mechanisms for expediting the development and accessibility of promising new therapies to treat AIDS and other serious illnesses. Regulatory requirements have been reduced and consultation with the FDA to discuss the planning and design of clinical research is encouraged.

Introduction

During the last decade, the process by which the FDA regulates investigational new drugs has become a renewed focus of national attention, primarily as a result of the AIDS crisis. In response to this crisis, the FDA has revised its regulations and created various formal mechanisms for expediting the development and accessibility of promising new therapies to treat AIDS and other life-threatening serious illnesses.

Milestones in U.S. Drug Law

Prior to 1906, there was no effective mechanism for drug regulation. Recognizing the need for stricter regulations to protect the public from exposure to inferior and harmful substances, Congress passed the Federal Food and Drugs Act of 1906 which prohibited misbranded or adulterated food and drugs from interstate commerce. However, this first drug law required only that drugs meet official standards of strength and purity and did not eliminate widespread abuses in medicinal enterprises.

In 1937, a manufacturer marketed an "elixir" of sulfanilamide which was prepared by mixing the drug substance with diethylene glycol as

a solvent. The prevailing drug law did not require clinical or animal testing prior to marketing and, during a matter of several weeks, 107 people died of diethylene glycol poisoning.

This national disaster prompted Congress to pass the Federal Food, Drug and Cosmetic Act of 1938 which authorized the FDA to establish a regulatory system for obtaining premarketing clearance for all investigational new drugs. Under this act, a "New Drug" was defined as "any drug that is not generally recognized as safe and effective under the conditions prescribed, recommended, or suggested in the labeling . . ."

For the first time, manufacturers were required to submit a new drug application (NDA) containing evidence (i.e. results of "adequate tests by all methods reasonably applicable . . . ") that a drug was safe for its intended use. Marketing could begin 60 days after filing the application if the FDA posed no objections. In regards to clinical investigations of new drugs, the system that was established consisted of minimal regulation which left the protection of human subjects almost entirely to the discretion of sponsors and investigators.

In the early 1960s, the thalidomide disaster became apparent. Thousands of pregnant women in Europe who took this sleeping pill gave birth to children with major limb deformities. Thalidomide was not approved for marketing in this country, mainly due to the efforts of FDA medical officer, Frances O. Kelsey, who believed there was inadequate evidence of drug safety. However, thalidomide was being investigated in the U.S. and some women were exposed after the risk was known. Since IND procedures were so sloppy, women taking the drug could not be identified. Thus, the need to tighten IND rules became apparent.

Reacting to the thalidomide incident, Congress passed legislation in the form of the Kefauver-Harris Amendments of 1962 which tightened the FDA's control over drugs. Sponsors were required to submit reports of preclinical studies to justify their proposed clinical testing in humans, obtain informed consent from test subjects, keep accurate records, and report all findings resulting from the investigational studies to the FDA. In addition, the 1962 amendments required that there must be substantial evidence of a new drug's effectiveness for its intended use, before it can be approved for marketing. Substantial evidence of effectiveness was defined as ". . . evidence consisting of adequate and well-controlled investigations, including clinical investigations," by qualified scientific experts, "that the drug will have the effect it purports to have under the conditions of use prescribed, recommended, or suggested in the labeling or proposed labeling thereof."

This efficacy requirement was intended to protect patients from fraud and the potential dangers of reliance on ineffective drugs. The amendments also required drug manufacturers to operate in conformity with Current Good Manufacturing Practices (CGMP) and placed prescription drug advertising under FDA supervision. Finally, marketing of a new drug was only permitted after the FDA granted explicit approval of a NDA, rather than allowing the NDA to become effective through FDA inaction.

This legislation defined the broad outlines of the current system for investigational new drugs and evaluating their safety and effectiveness (1,2). However, the FDA's drug regulatory process is a dynamic one, as evidenced by the successful efforts of the agency to modify the regulations in order to facilitate the development and accessibility of promising new drugs to treat life-threatening and serious illnesses.

Phases of New Drug Development

The process by which drugs are developed and approved consists of various phases of research, testing, and review, which takes on the average approximately 100 months (Figure 1). Usually 1-3 years of research are committed to the synthesis and preclinical testing of the drug before human studies can begin. Several years of clinical study are required before a new drug can be approved for marketing. Phase I clinical studies are performed to determine the dose-limiting toxicities, pharmacokinetics, and safe starting dose in humans.

These studies are typically conducted in a limited number of individuals, usually normal volunteers. However, in the case of drugs for cancer or AIDS, these studies are ordinarily performed in patients. Phase II studies are usually the initial controlled evaluation of a drug's activity. Phase III studies are expanded well-controlled trials conducted to better assess a drug's effectiveness and safety in larger groups of patients as well as to assess the effects of long-term use, to define dose, to study drug interaction, and to examine different populations. Most drugs proceed through these phases but this describes common practice, not regulatory requirement. If the results of Phase II studies show clear evidence of benefit in a severely debilitating or immediately life-threatening illness and the safety base is adequate considering the benefit seen, marketing approval can be based on these results. Often the manufacturer will agree to post-marketing studies.

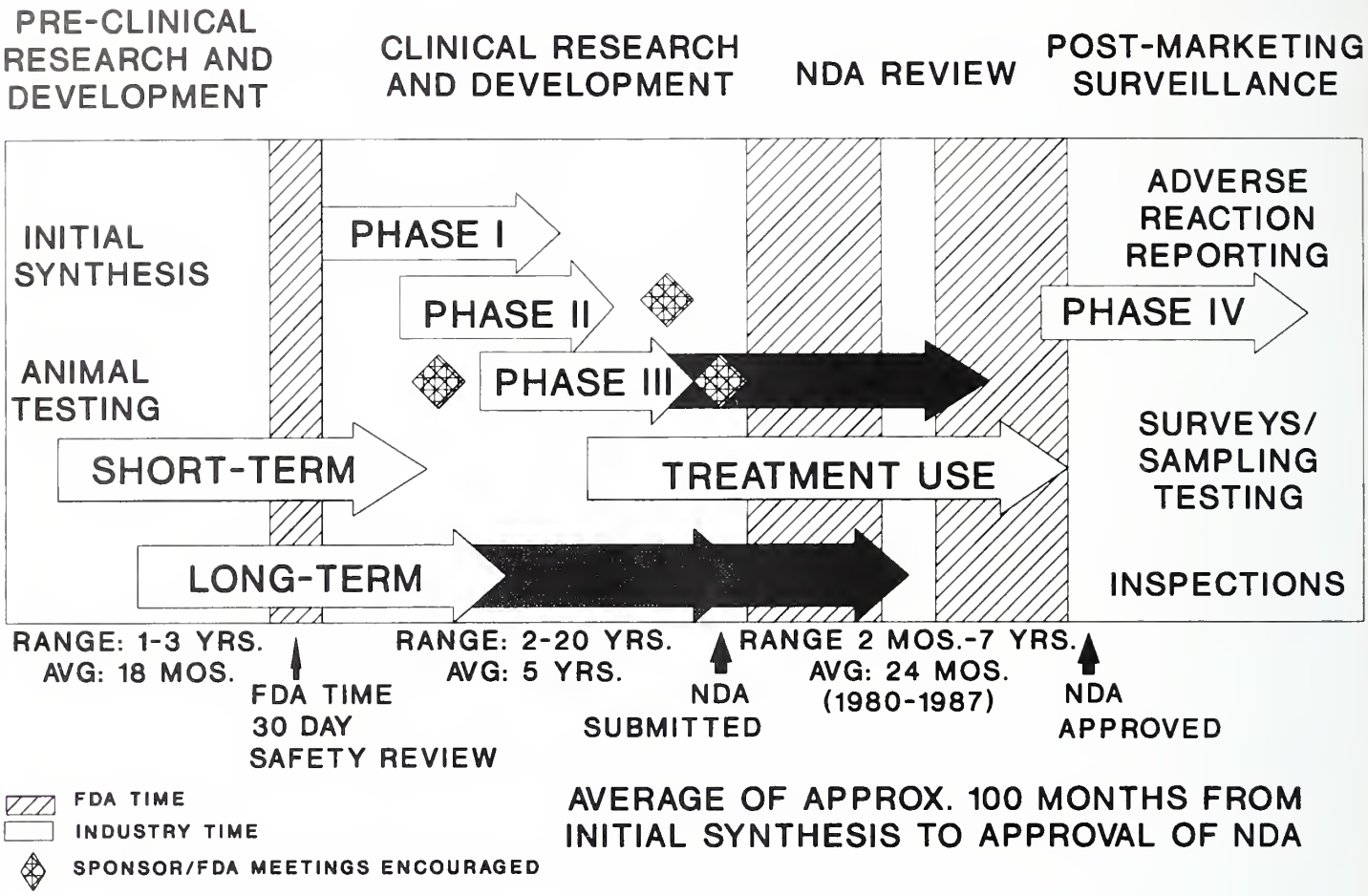
During this post-marketing surveillance phase, adverse drug reactions are reported to the FDA by the manufacturer, health professionals and other sources. The FDA may occasionally approve a drug with the understanding that the sponsor conduct post-marketing Phase IV studies. Phase IV studies may be needed to evaluate the efficacy of an approved drug for a new indication, a new dose or schedule of administration, elucidate the existence or frequency of adverse reactions, or safety and efficacy in a patient population not adequately evaluated during the premarketing phase (e.g. children, elderly, nursing mothers, etc.). A sponsor may choose to submit the data from Phase IV studies in support of labeling modification.

New Drug Review Process

IND Process

Prior to any clinical testing, the sponsor of a new drug must file an investigational new drug application or IND for FDA review. An IND may be sponsored by industry, academics,

NEW DRUG DEVELOPMENT



individual patient care physicians, or governmental agencies such as the National Institutes of Health. The IND allows the sponsors to conduct the clinical research necessary to obtain marketing approval for the drug or answer research questions involving the drug (i.e., it has some characteristics of a license). The IND process also serves as a monitoring device by which the FDA can be ensured that patients are being adequately protected.

An IND application must contain details of the drug's chemistry and manufacturing process and sufficient preclinical pharmacological and toxicological data for the FDA to conclude that it is reasonably safe to proceed with the initial clinical studies. The IND also must include the protocol(s) describing the proposed clinical study or studies, a description of previous human experience with the drug, the qualifications of the clinical investigators, and assurance that human testing will not be started until 30 days have elapsed and Institutional Review Board (IRB) approval is explicitly obtained.

Each IND application is reviewed concurrently by a medical officer, a pharmacologist, and a chemist in the responsible reviewing division. The FDA has 30 days to review the IND to determine whether it is sufficiently safe to proceed with the proposed study. If a sponsor does not hear from the FDA in that period, the study may begin. The FDA can put the IND on "clinical hold" if the division director decides that the study exposes subjects to excessive risks or the IND application is lacking in sufficient information to make an adequate assessment of the risk. If a study is placed on clinical hold, the FDA informs the sponsor that the study cannot proceed, communicates the specific inadequacies of the study, and makes recommendations as to how the deficiencies can be corrected.

Sponsors of an IND must submit additional protocols as amendments to the IND before they are implemented but there is no further 30-day pause for these new studies.

Sponsors are responsible for submitting safety reports to the FDA of any adverse experiences with the use of the drug that is both serious and unexpected. Sponsors must also submit annual reports which briefly describe the past year's progress of the investigation, including summaries of the status of each study in progress or completed, summaries of IND safety reports, a list of subjects who died during or dropped out of the drug study, results of preclinical studies, any significant manufacturing changes, foreign marketing developments, and a description of the general investigational plan for the coming year.

IND Rewrite

It became apparent to the FDA that the IND regulations were unclear and unduly troublesome in certain areas, particularly for individual and academic investigators. Consequently, the FDA modified the federal regulations regarding IND requirements in March 1987 and created the "IND Rewrite" which elucidated the requirements that were ambiguous under the previous regulations and established a less complicated set of requirements for early phases of clinical research. The IND Rewrite also clarified the requirements for reporting adverse drug events and the basis for imposing clinical holds.

In order to reduce impediments to scientific creativity and give sponsors greater latitude in the design of Phase I clinical studies, the FDA changed its regulation of this phase from concern with both safety and adequacy of study design to a primary focus on safety. This way a clinical hold in Phase I must be based on concern over a significant patient risk, not just dissatisfaction with the study design. In the later phases of clinical development (Phase II and III), the FDA considers not only safety but also the adequacy of the study design to produce valid data to meet the requirements for premarket approval of the drug. Such attention to the scientific merit of the studies would tend to decrease the number of NDA's that are not approved because of flawed study design.

Another major objective of the IND Rewrite is to facilitate consultation between the FDA and sponsors early during the drug development process. The FDA, therefore, encourages "End of Phase II" meetings to agree on the appropriate design of the pivotal studies that will form the basis for marketing approval and "Pre-NDA" meetings to provide guidance to sponsors as to the methods of submitting the data to facilitate the review process.

The IND Rewrite also provides exemptions from the need to submit an IND for most studies of drugs already approved for marketing. Studies are exempted if the proposed investigations are not associated with increased risk and are not being conducted for the purposes of changing the drugs' labeling or advertising. Most studies proposed by academic institutions would be exempt under this provision. Such studies, as they are investigations, do require informed consent and IRB approval.

The new regulations under the IND Rewrite are consistent with the FDA's goal of reducing the administrative impediments of early clinical research.

NDA Process

Once the clinical trials intended to provide evidence of effectiveness are completed, the sponsor prepares a NDA to market the drug. This document is submitted to the FDA for review and approval and consists of massive amounts of supportive information, including details of the drug manufacturing process and chemistry, preclinical and clinical pharmacological and toxicological information, and results of the clinical studies supporting the drug's safety and effectiveness. The NDA is scrutinized simultaneously by the FDA review team which consists of specialists in medicine, pharmacology, chemistry, biopharmaceutics, and statistics.

FDA regulations regarding NDA submissions were clarified in the "NDA Rewrite" of 1985. In addition, the FDA has published specific guidelines regarding the content and format of various sections of the NDA. The clinical data, controlled trials supporting effectiveness and controlled and uncontrolled studies providing evidence of safety, are by far the largest part of the NDA. An application to be approved, must contain two well-controlled studies supporting effectiveness. The FDA considers the appropriateness of trial design and analysis, and steps taken to minimize bias to be important elements of an adequate and well-controlled study.

Included in the NDA is the sponsor's proposed drug labeling and package insert. It is the FDA's responsibility to determine whether the claims concerning safety and efficacy, as stated in the proposed labeling, are supported by the scientific information in the NDA. The important issues regarding federal regulation of prescription drug advertising and promotion and how these relate to drug labeling are becoming an increasing challenge for the FDA (3).

Expediting Drug Development

The Role of the FDA

The FDA is responsible for a number of recent procedural changes which have enhanced the development and accessibility process for promising new drugs for the treatment of serious and life-threatening diseases (4,5). In addition, the FDA is striving to improve the quality of its review staff by recruiting highly qualified specialists and enhancing the professional development opportunities for existing staff.

Drug Classification

Since FDA resources are limited, the Agency assigns review priorities for INDs and NDAs according to a drug classification based on a drug's chemical type and potential therapeutic benefit. An application for a drug which may effectively treat a disease not adequately treated by a marketed drug (Classified "A") is given a higher priority than one for a drug that offers only a modest ("B") or no ("C") therapeutic advantage over other marketed drugs. Due to the interest in developing effective treatments for AIDS, the FDA gives all AIDS-related drugs and claims the highest priority.

Orphan Drugs

The Orphan Drug Act of 1983 was enacted to provide incentives to

manufacturers to bring market certain new drugs which were potentially valuable in treating diseases and conditions that affect only a relatively small number of individuals (i.e. prevalence less than 200,000). This act provided tax advantages and marketing exclusivity for sponsors of drugs so designated.

In addition to designating Orphan Drug status, the FDA offers sponsors assistance in study design and, in some cases, provides financial assistance in the form of grants and contracts.

Treatment Use

The use of drugs under an IND, is by law, limited to investigational uses. This could suggest limitation of use to formal clinical studies. In fact, however, the FDA has for many years permitted the use of promising investigational agents for otherwise poorly treated conditions in a variety of settings where treatment, not investigation, was the primary intent. These uses had many names (e.g. "Compassionate Use" and "Emergency Use"), but in 1983 FDA proposed regulations defining such uses as "treatment INDs," special INDs intended to provide early access of promising new drugs for serious and life-threatening illnesses (4,5).

The treatment IND regulations became effective June 22, 1987, by which time they were recognized as particularly relevant to the treatment of AIDS. The intent, however, was broader, and indeed the regulations were designed and proposed well before AIDS was actually recognized. Investigational cancer drugs were distributed under a very similar system (Group C status) since 1970. The regulations also revised the conditions under which manufacturers may charge for an investigational drug that is the subject of a treatment IND. Under these new regulations, it is very easy to charge for a treatment IND drug so there will be incentives for drug companies to make potentially life-saving investigational drugs available.

The FDA will consider a treatment IND application if the following conditions are met:

1) The drug is intended to treat a serious or immediately life-threatening disease.

2) There is no comparable or satisfactory alternative drug or therapy available to treat that stage of the disease in the intended patient population.

3) The drug is under investigation in controlled clinical trials under an IND or all clinical trials have been completed.

4) The sponsor is pursuing marketing approval of the investigational drug with "due diligence."

The regulations define "immediately life-threatening" to mean "a stage of a disease in which there is a reasonable likelihood that death will occur within a matter of months or in which premature death is likely without early treatment." Examples of immediately life-threatening diseases include advanced cases of AIDS, most advanced metastatic refractory cancers, far-advanced emphysema, and advanced congestive heart failure. The FDA defines "serious diseases" as "diseases or conditions that cause major irreversible morbidity." Examples of serious diseases include Alzheimer's disease, advanced multiple sclerosis, progressive ankylosing spondylitis, and advanced Parkinson's disease.

The FDA recommends that sponsors consult with the agency prior to the submission of a treatment IND to discuss the appropriateness of the submission. Once the treatment IND is submitted, the reviewing division decides, usually within a few days, whether or not the application is approvable. The final approval or disapproval of the treatment IND application is made at the level of the commissioner within 30 days. The criteria for allowing a treatment IND for a life-threatening disease are intended to be somewhat easier than for a disease that is "merely" serious. The commissioner may deny a request for a treatment IND for immediately life-threatening illness if the "available scientific evidence, fails to provide a reasonable basis for considering that the drug may be effective for its intended use in its intended patient population; or would not expose the patients to whom the drug is to be administered to an unreasonable and significant additional risk of illness or injury." The commissioner may deny a request for a treatment IND for a serious disease if there is "insufficient evidence of safety and effectiveness to support such a use."

Subpart E Interim Rule

Prompted by then Vice-President Bush's request to develop procedures for expediting the marketing of new therapies intended to treat AIDS and other life-threatening illnesses, the FDA in October 1988 issued new procedures called "Subpart E Interim Rule." When a drug has a favorable effect on survival or irreversible morbidity, it does not require a large safety data base to conclude that its benefits outweigh its risks. In fact, if the controlled trials of Phase II show such a benefit, the expanded trials of Phase III are usually not needed for approval.

The key component of the Subpart E Interim Rule is a mechanism for sponsors to consult with the FDA early in the drug development process. Sponsors are encouraged to request an end-of-Phase I meeting to reach an agreement on the design of Phase II controlled clinical trials with the goal that such testing will be adequate to demonstrate an effect on survival or irreversible morbidity and support an approval decision for marketing the drug. This potentially avoids the need for more extensive and lengthy Phase III trials.

Through the development and implementation of these new investigational drug regulations, the FDA has taken steps to simplify and expedite the clinical trial stage of drug development. Regulatory requirements have been reduced and consultation with the agency to discuss the planning and design of clinical research is encouraged.

A strong initiative for these regulatory changes was the success with the clinical development and availability of the anti-AIDS drug zidovudine (Table I). The evidence of efficacy and safety coming out of one multicenter Phase II, randomized, placebo-controlled study was so strong that Phase III trials of this agent were not required. Shortly after the Phase II trials were terminated, the FDA

TABLE I
Development of Zidovudine

1964	Azidothymidine (AZT, now known as zidovudine) developed as a potential cancer treatment. Shelved because of ineffectiveness.
October 1984	Preclinical tests begin for use as antiviral to treat AIDS
May 1985	IND application submitted
July 1985	Phase I studies begin
February 1986	Phase II studies begin
September 1986	Trials terminated — Phase III studies not done
October 1986	Treatment IND approved
December 1986	NDA submitted
March 1987	NDA approved

approved a Treatment IND which made the drug available to patients who were not enrolled in investigational studies. It took less than 2 years from the time the original IND was submitted to the time of NDA approval. The FDA reviewed and approved the NDA for zidovudine less than 4 months after it was submitted by Burroughs Wellcome.

Acknowledgments

I am indebted to Robert Temple, M.D., director of the FDA Office of Drug Evaluation I, for his invaluable advice and review of this material.

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The *West Virginia Medical Journal* will not consider for publication a paper or work that already has been reported in a published paper, or is described in a paper submitted or accepted for publication elsewhere.

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Use double spacing throughout, including (in the following order) title page, abstract, text, acknowledgements, references, tables, and legends for illustrations. Begin each of the following sections on separate pages: title page, abstract, text, acknowledgements, references, individual tables, and legends for illustrations. Number pages consecutively, beginning with the title page. Type the page number in the upper right-hand corner of each page.

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All persons designated as authors should qualify for authorship. Each author should have participated sufficiently in the work to take public responsibility for the concept.

The second page should carry an abstract of no more than 150 words summarizing the manuscript.

Where reference is made to generically-designated drugs, the first such reference must be followed by parentheses containing the most commonly known trade-name drug of that designation. In addition, a listing of all generic drugs mentioned in the article, with their trade-name equivalents, should appear at the end of the article.

Tables (tabular listings) and figures (photos, drawings and charts) should be numbered and the point of reference in the text indicated in parentheses, i.e., (Table 1), (Figure 1).

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Number references consecutively in the order in which they are first mentioned in the text. Identify references in text, tables, and legends by arabic numerals (in parentheses).

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President's Page

Michael M. Stump, M.D.

Goals, Organization and Details

A long time ago, I had the pleasure of attending a few weeks of academic postgraduate seminars at the University of Indiana School of Business. During these sessions, I had the personal good fortune of being invited to dinner at the home of the dean of the school. Appreciating this man as a respected and productive person, I asked him if he could capsulize what made an enterprise successful and I have never forgotten his reply.

"Whatever your goal -- the first great law is organization and the second great law is meticulous attention to detail!"

I thought on this long and hard even after I had left the school and returned home. Like so many other great truths, the language used to express it was amazingly simple and to the point. What had previously seemed so complicated and complex about organizations, companies and societies was now much more straightforward and direct. As I applied the principle in my own life, many things fell more easily and understandably into place.

I can state with certainty that the goal and primary purpose of the West Virginia State Medical Association is the advancement of the art and science of medicine and the betterment of public health. This goal is similar or identical to the main purpose of the American Medical Association and supports applying all possible effort to make medical services of high quality available to all individuals.

The WVSMA, however, is now faced with the necessity of additionally organizing itself along lines of legislative and political education in order to continue the betterment of the public health and protect the profession. It is now not enough to simply take care of patients in their pursuit of health and freedom from illness -- we must now add political, social and community expertise to our medical abilities so that we may peaceably continue our major calling.

Along these lines, it has been necessary to consider and formulate concepts and adapt our staff structure. We must and are developing programs, initiatives and strategic plans to take into account the changing environment in which we find ourselves.

As an example, the WVSMA Executive Committee and staff recently completed a productive retreat in which we spent an entire weekend from Friday afternoon until Sunday noon carefully examining an extensive range of subjects.

We reviewed the primary WVSMA strategic plan in great detail, including its breakdown into subtopics such as government relations, communications, socioeconomic issues/alliances, membership/benefits, scientific/educational and internal/external structure.

In a similar fashion, we covered many other important topics such as the innovative new timeline program to establish manageable goals and objectives for the WVSMA including planned schedule for implementation; membership and recruitment efforts; young physicians; financial status; non-dues revenue programs; organizational structure; officer and staff functions; outside contracts; and regional meetings with component societies. In addition, three very major and interconnected subjects were examined in depth -- communications/publications, health care issues, and legislative matters.

The topics which I have mentioned are just one portion of the programs, initiatives, plans and strategies that are currently in place, beginning and evolving or yet to be born.

"Whatever your goal -- the first great law is organization and the second great law is meticulous attention to detail."

Michael M. Stump, M.D.

Editor's Note: *Dr. Stump's April message "Some Good Things Happen" was reprinted in the April 18 edition of The West Virginia Hillbilly.*

Votes

It is nothing but surprising that politicians, interested as they properly might be in votes, have not noticed that there are votes out there among those in the medical community.

That one group includes other than doctors. There are, of course, nurses and aides, medical assistants of various kinds, numerous technologists, a bevy of assorted hospital administrators, a CEO or two, office personnel of all genre, hospital cooks, food service employees, housekeeping and other maintenance workers, librarians and recordkeepers, pharmacists and that rather large group from the pharmaceutical industry with its manufacturing, executive, sales, distribution and research components.

We might even add to this number various support industries such as housing workers, automotive and manufacturing equipment makers, grocers, cleaners, tailors and others in the clothing industry, farmers and grocers to feed all these and the list could go on.

Much tongue clucking invariably accompanies the frequent revelation of the fact that medical care now accounts for 12 percent of the GNP. Granting that those responsible for that 12 percent are unlikely to be in the lower income group, still, those in what is now termed the medical care industry easily comprise at least 10 percent of the national income *producing* group and at least a similar percentage of the population as a whole.

Considering also that high income producers are the most consistent and predictable voters, we medical industry workers probably represent somewhere between 10 percent and 15 percent of votes cast in any election.

Now, that number of votes has to be significant. Why, it even approaches the number claimed by the gay community -- and consider the political homage paid to them.

We need to be designated a minority group. God knows, we are discriminated against by legislators, government regulators, insurance companies, courts, the media -- you name it. Daily we are made to feel guilt stricken because we fail to give our services free to some suffering segment of humanity. Yet, no one else is expected to do this -- not even the church anymore.

What industry is more controlled and regulated? Are lawyers or septic tank cleaners told how much they may charge for their services?

It is time for politicians to count noses and votes. It is time for them to stop extracting the cost of their political philanthropy from this minority group. We are tired of giving and getting no credit for what we give. We are tired of feeling guilty for charging anything at all for our services. It is time to add up the votes.

—SDW

Difference of Opinion on HB 2461, Midwife Bill

After reading the letter by Dr. Wallace Johnson which appeared in the April *Journal*, I feel he is seriously misinformed about two issues.

HB 2461, which establishes the West Virginia Health Care Commission, was developed by the Legislature in association with Governor Caperton as a result of continued concern about the state's health care system, or lack thereof, especially as it relates to availability, accessibility, and affordability of basic health care services. Contrary to Dr. Johnson's assertion, all of the seven members of the Health Care Commission must have experience in health care. "Two of the members, . . . shall be full-time state officials having involvement in and impact on health policy for the state. The other five members shall be appointed . . . on the basis of their ability, experience, and interest in health care and on their ability to represent the diverse geographic health care needs of the state."

Clearly, the intent in creating this commission and the charge to them is to address in a comprehensive manner the serious health care issues facing all West Virginians. Dr. Johnson, as well as all of us, need to work with the commission and provide objective input to their efforts instead of "badmouthing" the effort.

The second issue addressed in Dr. Johnson's letter is even more troubling. As a public health physician with broad experience both nationally and internationally, I supported SB 485 - the midwife bill. The following are my reasons as expressed to the legislators:

1) The number of doctors, nurse midwives and others who are delivering babies in the state has dropped to below 100.
2) The birth rate, however, stays the same at approximately 22,000/year.
3) Few obstetricians are willing to practice in rural areas.
4) Few family practitioners are willing to practice obstetrics.
5) The number of nurse midwives is very small.
6) Most obstetricians, family practitioners and nurse midwives will deliver babies only in a hospital or birthing center.
7) Some individuals prefer a home setting for their child's birth. In 1988, there were 101 out-of-hospital births and in 1989 there were 69, with most of these being home births.
8) The non-nurse midwife has traditionally been prevalent in other countries as a valuable resource to families, but now is becoming increasingly important in the U.S.
9) In West Virginia, however, the non-nurse midwife has not been recognized. Consequently, those families wishing to be attended by one have run risks since physician consultation, referral, and transfer to hospitals in cases of complications have not always been adequately planned for.
10) A system of licensure of midwives who will care for those in hard to reach places and those whose first choice is the home-birth alternative will assure adequate oversight and surveillance, thus making the home birth as safe as possible.
11) I have seen first hand in New Hampshire how such a system can work. We developed a comprehensive application and evaluation of expertise procedure, strict practice guidelines, and a system of review of any problem cases with the assistance of experienced midwives, nurse midwives, and physicians.
12) Finally, then, West Virginia needs all the obstetrical and midwife practitioners it can get. There is a place for all - the M.D., the nurse midwife and the licensed midwife. Neither infringes on the other's turf as they each serve difference clientele and it is only through licensure and supervision of practice enabling legislation that the public's health can be best served.

Once again we all need to work together to assure our citizens of the quality care that they deserve and which is their right but unfortunately, cannot be afforded or is otherwise not accessible to every citizen. Dr. Johnson, a gastroenterologist, has the right to choose not to practice obstetrics, but his inflammatory and ill-informed statements do nothing to improve the plight of the families in the state who cannot obtain obstetric or midwife care.

William T. Wallace Jr., M.D., M.P.H.
Commissioner, Bureau of Public Health

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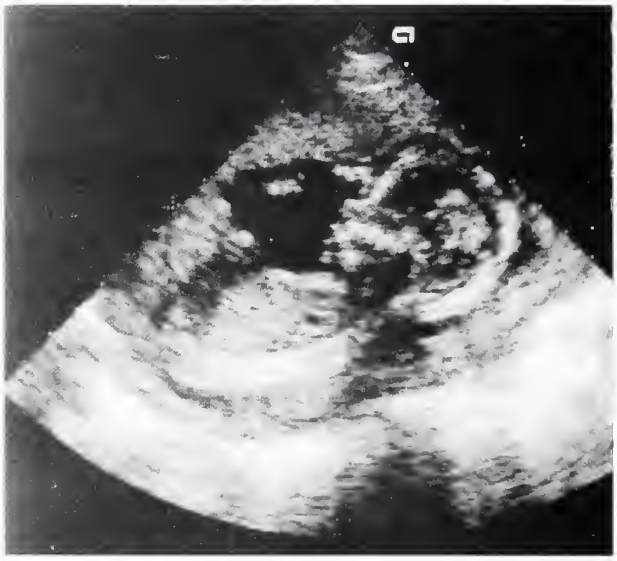

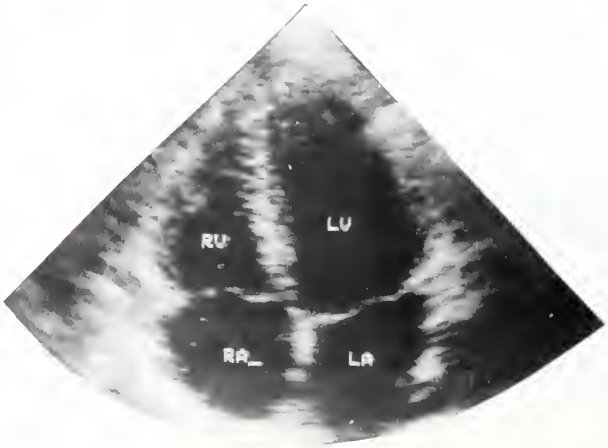

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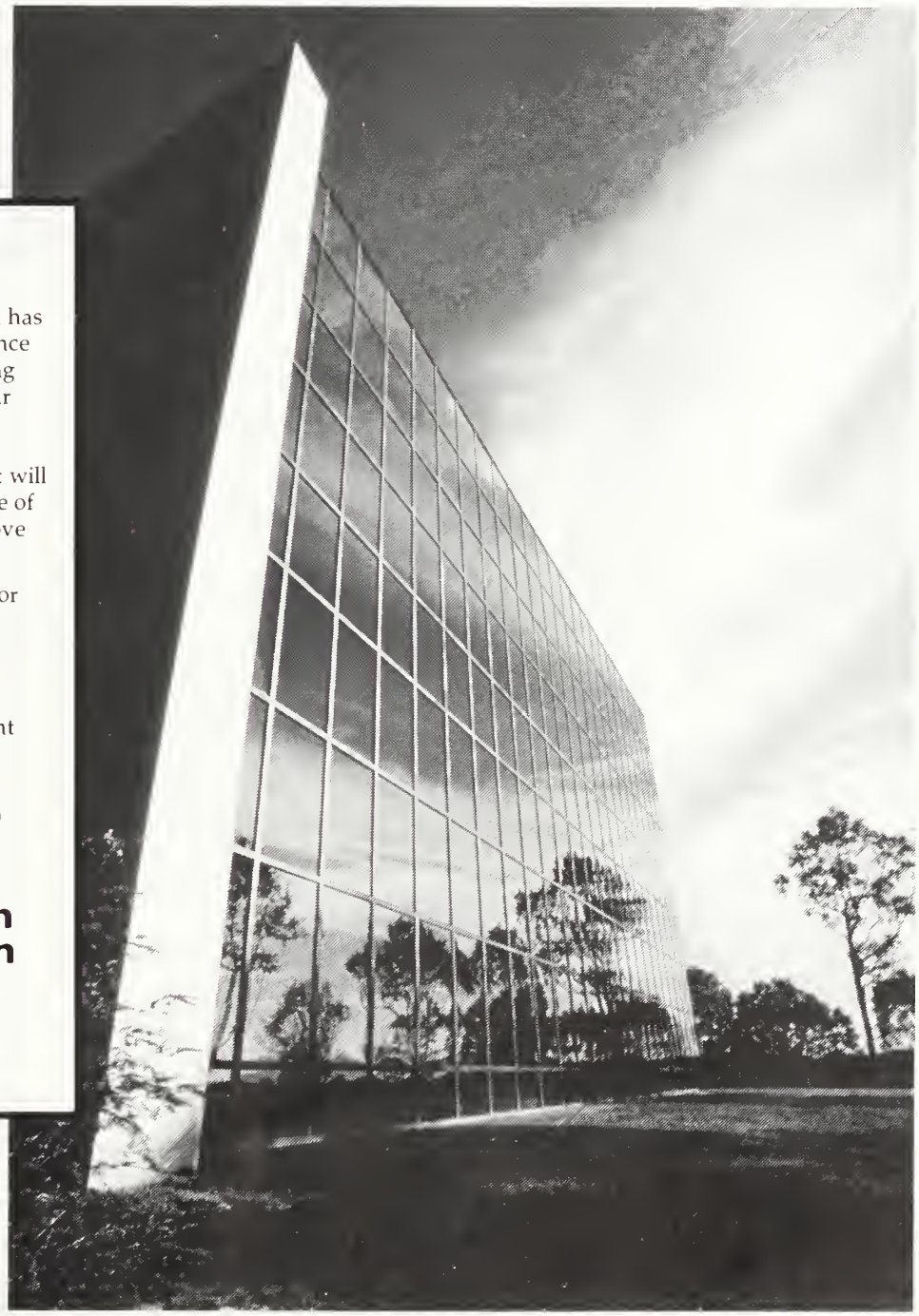

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First Session to Highlight Role of Regulators

"Regulators' Recipe for Patient Care" is the title of the First General Session at 9 a.m. on Thursday, August 15 which will be held during this year's WVSMA Annual Meeting at The Greenbrier.

Stephen L. Sebert, M.D., will moderate this discussion which will begin with Sister Eileen Catterson, M.D., FAAP, president of the West Virginia Board of Medicine, speaking on "Rules and Regulations of the West Virginia Board of Medicine: Who is Watching Who?" The next panelist will be Harry S. Weeks Jr., M.D., medical director of the West Virginia Medical Institute, who will address the subject of "The PRO Program." The final presenter will be Joseph P. Schock, MPH, PE, director of the Office of Environmental Health Services for the state of West Virginia, who will talk about "Environmental Health — The Infectious Waste Act."

Catterson

Weeks

Schock

Speakers Profiled

Dr. Catterson is a native of New York City who graduated from the Maryview Hospital School of Nursing in Portsmouth, Va. After receiving her degree, Dr. Catterson worked at Maryview Hospital for four years, first as a staff nurse and then as a nursing supervisor and clinical nursing instructor.

A Roman Catholic nun of the Daughters of Wisdom Order, Dr. Catterson was sent to Africa in 1962 to work as a missionary nurse and run an orphanage in Nguludi, Malawi. Her experiences during the five years she spent in Africa made Dr. Catterson feel she could accomplish more as a physician, so she enrolled in medical school as soon as she returned to the U.S. In 1974, Dr. Catterson obtained her medical degree from the Medical College of Pennsylvania in Philadelphia and moved to Akron, Ohio, for three years of postgraduate studies at Children's Hospital of Akron.

From 1977-80, Dr. Catterson held a faculty post at the University of Wisconsin College of Medicine and in 1978 was a preceptor at the Marshall University School of Medicine. During this same time, she opened a non-profit clinic in Rhodell, W.Va., in conjunction with the Daughters of Wisdom. In 1985, she started another non-profit clinic with the Catholic Church, Pineville Children's Clinic in Pineville, W.Va., where she currently practices pediatrics.

Since 1984, Dr. Catterson has also been president of the West Virginia State Board of Medicine. Extremely active in community activities and children's issues, Dr. Catterson has served on the Headstart Health Advisory Committee in Wyoming County, the board of directors of the McDowell-Wyoming Child Protection Team, the advisory committee for Foster Grandparents, and the Advisory Board for Pre-School Handicapped Children.

In February 1988, Dr. Catterson received the West Virginia Celebrate Women Award for Outstanding Achievement in Professions. She was recently featured in the January 1991 issue of Contemporary Pediatrics in their series on national advocates for children.

Dr. Weeks received his medical degree from the University of Maryland School of Medicine in 1953 and then completed a rotating internship at Mercy Hospital in Baltimore. In 1954, he relocated to Wheeling to do a two-year residency in anesthesiology at Ohio Valley General Hospital.

From 1957 to the present, Dr. Weeks has been on the staff of the Ohio Valley Medical Center, where he served as president of the medical staff from 1982-83. In 1974, Dr. Weeks became a professor of anesthesiology at West Virginia University and the following year was also named medical director and president of the West Virginia Medical Institute, Inc. in Charleston.

A very active member of the WVSMA, Dr. Weeks was president from 1971-72 and has been an alternate delegate or delegate to the AMA since 1968. In addition, he currently serves as chairman of the Legislative Committee of the American Medical Peer Review Association and is involved with the Health Planning Council of West Virginia and the FLEX Exam Review Committee. He is a past president of the American Association for Professional Standards Review Organization.

Dr. Weeks is a Fellow of the American College of Anesthesiologists and a diplomate of the American Board of Anesthesiologists.

Mr. Schock has 36 years of management experience in environmental health and for the past 34 years has been an active duty commissioned officer with the U.S. Public Health Service. Besides his current role as director of the Office of the Environmental Health Services for the Bureau of Public Health for the state of West Virginia, Mr. Schock is director of Environmental Sanitation for the National Park Service (NPS).

In his present position, Mr. Schock develops rules and regulations on the handling, storage, transportation, treatment and disposal of infectious waste and helped create H.B. 2141, which was passed by the 1991 Legislature. He has instituted extensive randon and asbetos programs and prepared fee schedules and guidelines for the licensing of asbestos inspectors, abatement workers, randon mitigators, testers, contractors, as well as laboratories and x-ray facilities. He also recently coordinated the state's Low-Level Radioactive Waste Compact program.

Mr. Schock has a bachelor's degree in civil engineering from Marquette University and a master's degree in public health from the University of Minnesota. He has received three awards from the Public Health Service including a commendation medal for superior work in 1971, a unit citation for program accomplishments in 1985, and a citation for developing and conducting a survey of radon exposure in NPS housing.

Canada Site of July Medical Seminar

The 9th annual medical seminar at Plummer's Great Slave Lake Lodge in the Northwest Territories of Canada is entitled "Topics in Contemporary Medicine," and will be held July 20-27.

The meeting is sponsored by the North Memorial Medical Center, the University of Minnesota Department of Family Practice, and St. John's Regional Health Center in Springfield, MO.

For details and CME information contact 612-588-9478.

Research Day Winners

The winners of the annual Research Day competition sponsored by Charleston Area Medical Center and the Charleston Division of the WVU Health Sciences Center are (from left to right) Deniz F. Bastug, M.D.; Daniel Thistlewaite, M.D.; Emily de los Reyes, M.D.; John Dinesmore, M.D.; Larry L. Shears II, MSIV; and Keith L. Hassan, M.D. Drs. de los Reyes, Thistlewaite and Bastug were first, second and third place winners in the original research category. Third-year medical student John Dinesmore took first place honors in the subject review/case presentation category, with Dr. Hassan and fourth-year student Larry Shears tying for second place.

FDA Approves New Disposable Cholesterol Test

The first completely disposable test to measure total cholesterol has received clearance by the Food and Drug Administration (FDA) for use in doctors' offices. The Clinimeter™ Cholesterol Test, developed by Crystal Medical, has been judged by the FDA to be equivalent to larger, more expensive instruments used in doctors' offices.

"We expect Clinimeter to be available to physicians beginning in July through major U.S. physician market office distributors, allowing them to perform cholesterol measurement tests without making the significant capital investment required to purchase and maintain large instruments," John Schulte, president and CEO of Crystal Medical said.

Clinimeter measures total cholesterol from a fingerprick blood sample. It contains a patented plasma separator which rapidly separates plasma from whole blood without the need for centrifugation. Clinimeter also uses a patented thin film technology which permits a "thermometer-type" readout directly proportional to cholesterol concentration.

Remember to Renew WV Medical License

The West Virginia Board of Medicine reminds physicians that all licenses expire June 30 and that registration forms have been mailed to all licensed physicians.

One of the questions on the registration form relates to whether a physician has been addicted to or received treatment for any chemical substance or alcohol dependency during the last registration period - July 1, 1989 to June 30, 1991. Physicians must be aware that a new law took effect in 1990 which allows a physician who reports to the Board his or her participation in a chemical dependency or alcohol treatment program to enter into an agreement with the Board which imposes limitations on the practice of the physician. If the Board has not received nor filed any written complaints relating to the physician's alcohol or chemical dependency impairment, nor any reports relating to such an impairment from hospital medical peer review committees, courts or insurers, the agreement may be considered nondisciplinary and not public information.

First National Hepatitis Awareness Campaign Initiated

The American Liver Foundation (ALF) launched the first National Hepatitis Awareness Campaign (NHAC) on May 1 to alert the public of the widespread threat of chronic hepatitis C.

A toll-free hotline (800-223-0179) will be answered from 8:30 a.m. to 5 p.m. (EST), to field inquiries related to the disease, local educational efforts, and physician referrals. A free booklet, entitled "Hepatitis C: A Common But Little Known Disease," will be available to all callers on the 800 line and through local chapters of the ALF. In addition, walk-in blood screenings will be offered at hospitals in the largest U.S. cities.

"Chronic hepatitis C is a serious public health threat," said ALF Advisory Board Chairman John L. Gollan, M.D., Ph.D. "Through this national campaign, the American Liver Foundation hopes to educate Americans about hepatitis C, because it is critical that the disease be detected in its early stages, so that physicians can counsel their patients on treatment programs."

According to the Centers for Disease Control, hepatitis C is the most underreported of all types of viral hepatitis. Each year approximately 85,000 patients become chronically infected with the disease.

Two New Reports Issued by NIH

The National Institutes of Health (NIH) has compiled two new consensus development statements, "Clinical Use of Botulinum Toxin" and "Diagnosis and Management of Asymptomatic Primary Hyperparathyroidism."

Free single copies of these consensus statements are available from William H. Hall, Office of Medical Applications of Research, National Institutes of Health, Building 1, Room 259, Bethesda, MD 20892, (301) 496-1143.

Urological Society Meets

The West Virginia Urological Society met at the Charleston Marriott on March 23-24. Guest speakers included Drs. Fray Marshall and John Gearhart (far left), professors of urology at Johns Hopkins University, Dr. Gregory Slachta (fifth from left), chairman of the AUA Socioeconomic Committee; and Dr. Don Lamm (sixth from left), professor and chairman of urology at WVU. Pictured with these guest speakers are new society officers, Dr. Doug McKinney, secretary-treasurer; Dave Lindert, M.D., president; and Joe Plymale, immediate past president.

ASIM Meeting To Be Held in October

Washington, D.C. will be the site of the 35th Annual Meeting of the American Society of Internal Medicine, October 10-13.

The meeting will feature workshops to discuss the soon-to-be added time-based CPT codes, balance billing limits and how other aspects of physician payment reform will affect internists' practices. Other workshop topics to be covered will be geriatrics and the management of common ambulatory problems such as depression and drug dependency; the management of stress associated with "the hassle factor;" early testing and treatment for HIV infection; and medical-legal issues such as "right to die," living wills and "do not resusitate" orders.

HCFA chief Gail Wilensky has been invited to keynote the meeting. Plenary programs will focus on mechanisms being proposed by public and private payors to control/utilization while expanding access and updates on the development of practice guidelines, the RBRVS Medicare fee schedule and other payment reforms.

Contact Lisa Derby at (202) 289-1700 ext. 615 for more details.

Lake Tahoe Seminar Focuses on Front Office Skills

The Practice Management Institute of Lake Tahoe, a new educational retreat devoted to practice management, will hold a seminar entitled "The Pinnacle for Front-Office Staff," September 25-29.

This seminar will be held at the Granlibakkan Resort at Lake Tahoe and is designed to reinforce professional skills and teach front desk staff new techniques to increase efficiency of medical and dental offices. Topics that will be covered in the three-day retreat include:

- Minimizing malpractice risk
- Dealing with insurance companies
- Handling complaints and unreasonable demands
- Developing a telephone protocol
- Developing superior personal skills
- Handling stress more productively

Registration is limited and more information can be obtained by calling Janet Schueller at 1-800-726-1308 from 6 a.m. to 4 p.m. (PST).

Dr. Mairs Honored

Dr. Daniel A. Mairs (left) is congratulated by Dr. William O. McMillan for receiving the third William J. Maier Education Award given by West Virginia University. Dr. Mairs, a native West Virginian and practicing physician for over 30 years, was honored for his dedication to students and residents at the WVU Health Sciences Center and his unselfish service to patients.

New Medical Alumni Chapter Organized

The West Virginia Chapter of the University of Sto. Tomas Alumni Association in America was recently organized by Dr. Rano S. Bofill of Man. The University of Sto. Tomas is a medical school in Manila, Philippines that was founded in 1611 and has the largest number of Philippines medical graduates in the U.S.

The WV Chapter will be the newest component society to the national organization and their elected officers include Max Tan, M.D., Williamson, president; Rene Sullesta, M.D., Charleston, vice president; Plaridel Tordilla, M.D., Man, secretary-treasurer; and Dr. Bofill is serving as an advisor to the Board of Trustees.

Among the other members of this alumni group are Dr. Constantino Amores, president-elect of the WVSMA; Dr. Cordell de la Pena, past president of the WVSMA; and Dr. Jesus Ho, a member of the West Virginia Licensing Board.

AOA, Pan-American Ophthalmologists to Hold Joint Meeting

The American Academy of Ophthalmology and the Pan-American Association of Ophthalmology will come together October 13-17 in Anaheim, Calif., to exchange scientific ideas and information on the latest advances in eye and vision care.

This joint meeting marks the AOA's 95th annual meeting and the Pan-American Association's 18th biennial congress. It will be held at the Anaheim Convention Center and two adjacent hotels, the Anaheim Hilton and the Anaheim Marriott.

For more information, contact, Meetings Department, American Academy of Ophthalmology, P.O. Box 7424, San Francisco, CA 94120-7424.

Generic Pharmaceutical Booklet Available

The National Association of Pharmaceutical Manufacturers (NAPM), has published a new informational booklet entitled, "Generic Pharmaceuticals: A Matter of Dollars and Sense." These are now available to patients at many chain and independent pharmacies throughout the United States and are typically free of charge.

The pamphlet explores myths relating to the safety and efficacy of generic pharmaceuticals and responds to these "fictions" with "facts." It is intended for free distribution for patient use and is available to practices at a nominal fee. Space has been allotted on the back of the pamphlet for a medical practice name and address to be printed, if desired.

Copies can be requested by writing to NAPM, 747 Third Avenue, New York, New York 10017 or calling the Center for Information on Generic Pharmaceuticals, 1-800-688-6276, Monday through Friday, 9 a.m. - 5 p.m. EST.

ALAWV Offering Free Air Pollution Prevention Brochure

The American Lung Association of West Virginia is offering a free brochure on how to clean up the air and prevent air pollution.

The brochure, developed by the national American Lung Association, includes recommendations on planting trees, avoiding the use of aerosol cans and cleaning air conditioners, humidifiers and dehumidifiers to minimize the buildup of molds and other biological pollutants.

For a copy of "Clean Air is Up to You," contact the ALAWV at 342-6600.

American Pain Society Plans Fall Meeting

The American Pain Society (APS) will hold its 10th Annual Scientific Meeting, November 7-10, in New Orleans. More than 1,000 are expected to attend the meeting.

The APS Scientific Meeting provides a forum for promoting and encouraging interdisciplinary exchange among pain scientists and healthcare professionals. Topics range from the newest techniques and drug therapy, to the financial and political implications of delivery of care to patients.

For information about the meeting, contact Cathy Crabbe at (708) 966-5595.

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You enjoy all this while meeting fellow physicians exchanging ideas and knowledge in the medical arena. It is a continuing medical education event providing practical expertise for primary care physicians, specialists, residents, students and nurses.

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West Virginia State Medical Association
124th Annual Meeting
August 14 - 17
The Greenbrier
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Continuing Education

Listed on this page are some of the upcoming continuing education programs which will be held throughout the state.

The programs this month were compiled by the following individuals: Patricia Barnhart, WVSMA loss control coordinator, Suzanne Nowell, WVU outreach coordinator of CME; and Robin Rector, coordinator of CME for Charleston Area Medical Center.

These programs are tentative and subject to change. Further details about these CME activities may be obtained by calling Barnhart at 925-0342; Nowell at 293-3937; and Rector at 348-9580. Other national and state meetings are listed in the Medical Meetings Section of the *Journal*.

This schedule is presented as a convenience for physicians. If you would like to have the continuing education programs offered by your institution or association published in the *Journal*, please contact Nancy Hill, managing editor, at 925-0342.

West Virginia State Medical Association - Charleston

June 8 - WVSMA/CNA First Generation Loss Control Seminar, Charleston

June 22 - WVSMA/CNA First Generation Loss Control Seminar, Morgantown

July 10 - WVSMA/CNA Loss Control Seminar for Office Personnel, Wheeling

CAMC/WVU Health Sciences Center - Charleston

June 8 - "Norplant Training Program," CAMC/Women and Children's Hospital, 9 a.m.

June 10 - "Obstetrical Update," TC, Women and Children's Hospital Board Room, 12:30 p.m.

June 18 - "Dealing with Difficult People in Health Care," WVU Auditorium, 8 a.m.

June 24 - "Oncology Update," TC, WVU Building, Room 2000, 12:30 p.m.

Outreach Programs

Key to Sponsors

★ WVU Health Sciences Center, Morgantown

☐ CAMC (*)/WVU Health Sciences Center-Charleston (△)

(Check locally for additional information)

Fairmont ★ Fairmont Clinic, June 19, 1 p.m., "Pediatrics: A Review of Pediatric Immunodeficiency Syndromes," Paris T. Mansmann, M.D.

Logan ☐ Logan General Hospital, June 21, 11:30 a.m., "Aeromedical Transport Services," Stephan Hoppes

Man ☐ Man Appalachian Regional Hospital, June 18, 7 p.m., "Medical Ethics," Daniel Foster, M.D.

Point Pleasant ☐ Pleasant Valley Hospital, June 27, noon, "Spinal Cord Injuries," Mario Balmeseda, M.D.

Ripley ☐ Jackson General Hospital, June 14, noon, "Accessing Family Resources," Susan Watkins, Family Resource Center, Women and Children's Hospital.

Spencer ☐ Roane General Hospital, June 18, 12:30 p.m., "Trauma Update," Rob Wallace, R.N.

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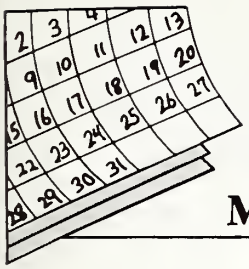


Medical Meetings

June

7-9—Advanced Medical Staff Seminar, West Virginia Hospital Research & Education Foundation, White Sulphur Springs.

9-13—Fifteenth Symposium on Lung Disease, Southern Medical Association, Sea Island, GA.

11-14—Society of Nuclear Medicine, Cincinnati.

13-14—Cardiology in Practice, Ohio State University, Columbus.

15-16—Second Annual Alumni Conference of the WVU Otolaryngology Department, Morgantown.

15-18—Elderfair, Temple University's Institute on Aging, Philadelphia.

19-23—1st Annual Spring Meeting, Southern Association for Geriatric Medicine, Vancouver, British Columbia.

21-23—Focus on the Chronically-Ill Patient, Southern Medical Association, Destin, FL.

24-26—8th International Congress on Group Medicine, Helsinki, Finland.

27-30—American Society of Contemporary Medicine and Surgery, Chicago.

27-30—American Society of Contemporary Ophthalmology, Chicago.

30-July 3—5th International Headache Congress, American Association for the Study of Headache and the International Headache Society, Washington, D.C.

July

12-14—Vascular Research Seminar, Ohio State University, Columbus.

14-19—16th Annual Meeting National Wellness Institute Inc., University of Wisconsin, Stevens Point, Wis.

19-21—National Conference on Breast Cancer, American Cancer Society, Chicago.

20-27—Topics in Contemporary Medicine, (Sponsored by North Memorial Medical Center and University of Minnesota Department of Family Practice, and St. John's Regional Health Center, Springfield, Mo.) Northwest Territories, Canada.

22-26—Association of Philippine Physicians in America, Atlantic City, NJ.

25-August 1—National Medical Association, Indianapolis.

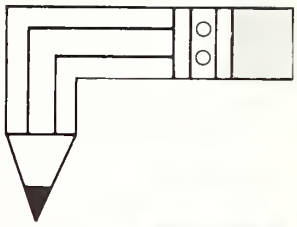
26-27—American College of Medical Quality, Orlando.

29-31—American Hospital Association, Anaheim, Calif.

For More Information . . .

Contact The Journal for additional information about most of the above meetings. Call (304) 925-0342.

Poetry Corner



Word Play

"Go fish," a childhood game of cards
We surely all have played
Was meant to occupy and entertain
And was free of harm and pain.

"Gone fishing," a sign to let us know
The owner of the country store
Had closed it down for just awhile
To try his luck, relax and smile.

"Fishing for a compliment"
We may have tried a time or two
And hoped someone might take the bait;
But many times we had to wait.

"Other fish are in the sea,"
Is a term we all have heard
When a heart was torn and in despair,
A hurt that time would soon repair.

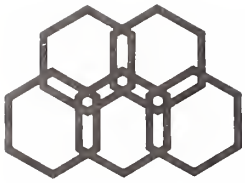
"Fishing in troubled waters," is an act
That has come to haunt a few of us
When we have interfered too much
In matters we should never touch.

A "fish story" most of us have told
When we have stretched a fact or two
Enlarging on the truth a bit
Hoping we can be a hit.

These quotes retain a common link;
They all refer to fish,
And show how varied are our ways
Of using language called "word plays."

E. Leon Linger, M.D.

Please address your submissions for Poetry Corner to: Stephen D. Ward, M.D., Editor, West Virginia Medical Journal, Box 4106, Charleston, WV 25364.



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- ☐ b. Worry about it tomorrow.
- ☐ c. Keep doing what you've done.
- ☐ d. Forget it - go on vacation.
- ☑ e. Call a CPA!

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For more information on using CPA services, send for our free brochure: The West Virginia Society of CPAs, Department A, P.O. Box 1142, Charleston, WV 25324.

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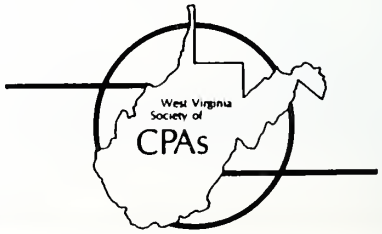
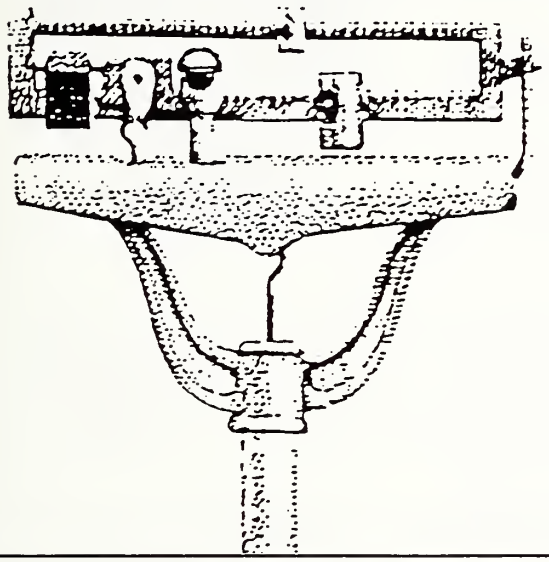


They've finally invented a machine that can determine someone's chances of heart disease, stroke and diabetes.



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WEST VIRGINIA UNIVERSITY HEALTH SCIENCES CENTER

Compiled from material furnished by the West Virginia University Health Sciences Center News Service, Morgantown.

Surgery Professor Helps Dedicate Historic Library

Herbert E. Warden, M.D., a WVU surgery professor who is a pioneer in the development of open heart surgery techniques, participated in the recent dedication of the new Lillehei Library at the University of Minnesota Heart and Lung Institute.

The Library of Cardiovascular and Thoracic Surgery, dedicated on April 19, was named for Drs. C. Walton and Richard C. Lillehei. C. Walton Lillehei, M.D., headed the team which included Drs. Warden and Morley Cohen, that made history on March 26, 1954, by performing the first open heart repair of a congenital defect on an 11-month-old boy.

The team had discovered earlier in laboratory research that the body can withstand substantially reduced blood circulation for 30-40 minutes, enabling surgeons to safely perform intracardiac procedures.

Using a cross-circulation technique with a heart pump developed in the laboratory, Dr. Warden's team used the boy's father to cross-circulate the blood during the operation. In the next year, the team performed 45 open-heart operations using the cross-circulation technique.

Dr. Warden has said, "Even now, those first opportunities to peer into the interior of a living, beating human heart for the first time were the most momentous, moving and humbling experiences I have ever had."

While Dr. Warden says one of the most "rewarding things" he's done in his medical career was to bring open heart surgery to the people of West Virginia by helping establish WVU's first cardiac surgery program, he is best known nationally for his participation in the first open heart surgery operation at the University of Minnesota Hospitals.

Gibson Named Head of OB/Gyn Faculty

Dr. Mark Gibson of the University of Vermont College of Medicine became chair of the Department of Obstetrics and Gynecology of the WVU School of Medicine on April 15. He will take the place of Dr. Donald Cox, who is retiring.

Dr. Gibson is a graduate of Yale and of the Case Western Reserve University School of Medicine, where he has taught since 1978.

"Dr. Gibson will provide leadership to the development of a statewide women's health program, with specific emphasis on the rural aspects of women's health," says Dr. Robert D'Alessandri, dean of the WVU School of Medicine. "He also has a special interest in reproductive endocrinology and infertility."

Two Surgery Residents Win Top State Honors

Two WVU Department of Surgery residents took top awards during the surgical resident paper competition at the annual meeting of the West Virginia Chapter of American College of Surgeons, May 2-4 at The Greenbrier.

First-place winner was Alexander Vasilakis, M.D., who presented a paper entitled "Non-Cardiac Uses of Extracorporeal Circulation: The Successful Resuscitation of a Hypothermic Multitrauma Patient." Dr. Vasilakis is a cardiothoracic fellow in the WVU Department of Surgery.

David R. Jones, M.D., a second-year resident, also won honors for his paper presented on "Effects of Calcium Chloride During Reperfusion in Hearts Arrested with Verapamil-based Cardioplegia."

In addition, three WVU surgery faculty members were elected to ACS leadership positions. Donald E. McDowell, M.D., FACS, was named president; Herbert E. Warden, M.D., FACS, was elected to his second term as governor; and Robert A. Gustafson, M.D., FACS, was re-elected as a councilor.

Spurlock Fellows Conduct Studies

Kimberley D. Bush of Jodie, W. Va., and Scott Caveney of Wheeling, have been selected as the first Edwin C. "Spud" Spurlock Summer Research Fellows. They will participate in basic science research projects at the Mary Babb Randolph Cancer Center for 12 weeks which are designed to determine the causes and best treatment of human cancer.

Bush is a student majoring in biology at West Virginia University. She is a 1989 graduate of Gauley Bridge High School.

Caveney is a freshman in the medical program at WVU and has been accepted into the M.D./Ph.D. program. He recently won the West Virginia Science Talent Search and his winning entry resulted in the publication of a scientific article in the *West Virginia Medical Journal.*

Baby Food Labels Earn $14,000 for Children's Hospital

WVU Children's Hospital has received $14,199.47 from Heinz Baby Food and the H.J. Heinz Company Foundation for the baby food labels collected in 1990.

Heinz pays six cents to the hospital for each label and since 1984, the facility has earned more than $60,000 for their efforts.

Consumers may send labels for the campaign to WVU Children's Hospital, Medical Center Drive, Morgantown, WV 26506-8111.

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MU School Of Medicine News

MARSHALL UNIVERSITY

Compiled from material furnished by the Office of University Relations, Marshall University.

Rural Clinic Receives National Practice Award

The Lincoln Primary Care Center, a clinical affiliate of the Marshall University School of Medicine, has been chosen to receive the Outstanding Rural Practice Award of the National Rural Health Association.

This award honors a rural medical practice which has improved access to rural people through innovative, comprehensive approaches and particularly recognizes effective outreach efforts, strong preventive health and educational programs, high-quality care provided efficiently, and strong community support and involvement.

"We were flabbergasted and pleased," said Dr. Robert B. Walker, chairman of MU's Department of Family and Community Health who has worked with the clinic since its earliest days. "The award is rarely won by practices in the eastern U.S.," he added.

Gerry D. Stover, the center's executive director, said he and his staff members appreciate the award on two levels. "It's wonderful to be acknowledged by experts who are evaluating your work from a distance," he said. "In addition, for us, this award represents a vote of confidence from our peers since many of the primary care centers here in West Virginia wrote letters supporting our nomination."

The Claude Worthington Benedum Foundation, which over the years has provided significant support for the clinic and its joint programs with Marshall, nominated the center for the award.

"At a time when rural health centers as a group are struggling, the Lincoln Primary Care Center proves that with imagination and cooperation a community health center can do more than survive -- it can flourish," Benedum officials said in their nomination materials. "LPCC is responsible for having dramatically improved health care for rural people in the region. In addition, it provides a lively learning environment which clearly demonstrates to medical students that rural practice can be successful," they added.

Marshall's School of Medicine provides doctors for the center, including specialists in family practice, pediatrics, cardiology, and surgery. In addition, medical students and family practice residents rotate through the center.

The Lincoln Primary Care Center provides approximately 27,000 patient visits per year, and is the county's only source of medical care after 5 p.m. weekdays and on weekends. It is a non-profit, community-owned and directed facility that is open 364 days a year. The facility was created in 1975 and was the first U.S. clinic to be classified as a rural health clinic under federal law.

This is the second time in three years that the association has honored a Marshall-related project. In 1988, the school's combined residency/practice plan was named the nation's outstanding rural health program. Participants in that program provided health care through the Lincoln County center as well as other sites.

Two Mental Health Specialists Join Psychiatry Faculty

Mental health services to children and adolescents are getting a much-needed boost in the Huntington area, thanks to recent faculty additions to the School of Medicine.

Sivanta R. J. Paul, M.D., a psychiatrist, and Thomas D. Linz, Ph.D., who specializes in child and adolescent psychology, are available to see troubled youth and their families on an outpatient basis and serve as consultants on hospitalized patients. They also provide evaluations and assessments for pediatricians, family practice physicians, schools, courts and other agencies.

"With Dr. Paul and Dr. Linz, we have a team who together help us address some unmet needs in health care," said Dr. C. Leon McGahee, chairman of the MU School of Medicine's Department of Psychiatry. Pediatricians and others concerned with children and youth have voiced concern about a lack of psychiatric inpatient consultant services as well as a shortage of outpatient services in the area, Dr. McGahee said.

Dr. Paul provides both biological treatment and psychotherapy, and Dr. Linz assesses mental and intellectual development, performs neuropsychological testing, and also delivers therapy to individuals and families.

11 Students Graduate from Satellite Nursing Program

The Marshall University School of Nursing awarded baccalaureate degrees May 11 to 11 Logan area students who earned their diplomas without ever having to leave their home community.

The students, all nurses with jobs and families in the area, met their degree requirements through a unique distance learning program. They may well be the first group of students in the country to obtain degrees by satellite.

The nursing courses were beamed from Marshall and West Virginia University via satellite to a classroom at Southern West Virginia Community College, where a television screen and a telephone hook-up tied them into their professor and another group of students at the originating campus site. A local facilitator with faculty credentials provided a teacher presence and helped guide classroom discussion.

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New Members

We are pleased to welcome the following new physician members to the WVSMA:

Asghar Farsaii, M.D.
4 Hospital Plaza
Suite 202
Clarksburg, WV 26301

Haythem Jabi, M.D.
1801 6th Ave.
Huntington, WV 25701

Michael Krasnow, D.O.
1151 Hal Greer Blvd.
Huntington, WV 25701

Stephen C. Lau, M.D.
1183 Driftwood Drive
Pittsburgh, PA 15243

Alan Lee, M.D.
200 Maplewood Ave. & Fairlea
Ronceverte, WV 24970

Ronald Paolini, M.D.
The Wheeling Clinic
16th & Eoff Sts.
Wheeling, WV 26003

John T. Porvaznik, M.D.
1325 Locust Ave.
c/o Fairmont General Hospital
Emergency Department
Fairmont, WV 26554

Gregory Saracco, M.D.
1021 Mt. De Chantal Rd.
Wheeling, WV 26003

Dipti Shah, M.D.
The Wheeling Clinic
58 16th St.
Wheeling, WV 26003

Pramod Shinghal, M.D.
Rt. 4 Box 9A
Weston, WV 26452

Norman L. Siegal, M.D.
410 Carriage Dr.
Beckley, WV 25801

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Lubin C. Alimario

Kanawha

*Robert L. Ghiz
Joseph E. Fernandes
S.S. Jamie

Mercer

Kishor S. Pathak

Monongalia

*Stephen L. Sebert

Ohio

*Steven C. Miller
*Byron L. Van Pelt

Parkersburg

Harry L. Amsbary
*Frank L. Schwartz

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Obituaries

Howard Webb Angell, M.D.

Dr. Howard Webb Angell, 95, of Baton Rouge, formerly of Charleston, died March 2, in Baton Rouge Retirement Center.

Dr. Angell was a native of Clifton Forge, Va., who received his medical degree from the University of Virginia. He was a member of the WVSMA since 1934 and a veteran of World War I. He was an eye, ear, nose and throat specialist in Charleston before his retirement.

Dr. Angell's funeral and burial was held in Clifton Forge. A memorial service was performed at Baptist Temple in Charleston.

Surviving is his wife, Edna Duncan Angell.

John Vandale Brannon, M.D.

Dr. John Vandale Brannon, 75, of Bridgeport, died on March 12 at United Transitional Care Center following an extended illness.

Dr. Brannon was a native of Bridgeport who attended Bridgeport High School and West Virginia University. He received a B.S. degree from Fairmont State College and then graduated from the University of Maryland Medical School.

Prior to World War II, Dr. Brannon instructed British and French aviation cadets. He served with the U.S. Army Air Corps as a commanding officer and flew B-29 missions over Japan during the war. In addition, during the Korean War, Dr. Brannon served in the U.S. Navy.

Dr. Brannon practiced medicine from 1952 until 1974 in Bridgeport and was director of Emergency Services at St. Mary's Hospital from 1974-76 and director of Emergency Services at United Hospital Center until his retirement in 1984.

A charter member of the Bridgeport American Legion Post 68, Dr. Brannon was also a member of BPOE, Masonic Late Lodge 63 in Bridgeport, the Scottish Rite chapters in Clarksburg and Wheeling, the Central West Virginia Shrine Club and Nemesis Temple in Parkersburg. He had been a member of the WVSMA since 1953.

Survivors include his wife, Betty Whaley Brannon; two daughters, Susan Runner, Fort Worth, Tx., and Beverly J. Miller, Toway, Calif.; one son, John V. Brannon Jr., San Diego; four grandchildren, Kristen Runner, Elizabeth Runner, Erica Miller and Laura Tisch; one cousin, U.S. Navy Captain J.J. Vandale (retired).

Maurice H. Maxwell, M.D.

Dr. Maurice H. Maxwell, whose long career as a physician spanned nearly 40 years, died Monday, February 25, at the Winchester (Va.) Medical Center.

Born Jan. 23, 1915 in Keyser, he was the son of a physician, Dr. M.H. Maxwell. His mother was the late Albina (Godfrey) Maxwell.

Following his early education in the Mingo County public schools, Dr. Maxwell attended Emory and Henry College, graduating in three years. He received his medical education at Temple University Medical School, and took his internship and residency at hospitals in York, Pa., and Elkins.

Prior to entering private practice in Moorefield in 1946, he was employed as a mining company physician in Red Jacket. In 1951, he was president of the Potomac Valley Medical Society.

Dr. Maxwell was often the only physician in Moorefield during the years until his retirement in 1983. In the early days he rode horseback to visit his patients.

Survivors include his widow, Jane (Armentrout) Maxwell; two sons and daughters-in-law, Maurice H. Maxwell, Jr. and Rebecca Y. Maxwell, Farmville, Va.; William C. and Rosemary B. Maxwell, Salem, Va.; three grandchildren.

County Society

Monongalia

Carlos Jiminez, M.D., of Ohio Valley Medical Center spoke on physician interaction at the April meeting of the Monongalia County Medical Society.

Drs. Charles Mann, James Helsley, Robert Vance and M. Gibson were all approved for membership.

CNA's Third Generation Seminar

at the WVSMA Annual Meeting

CNA's new "third generation" seminar will be a special feature at this year's West Virginia State Medical Association Annual Meeting. The program is conducted by presenters trained in malpractice litigation and is designed to increase physicians' knowledge of the legal system as it applies to malpractice cases. The seminar is scheduled for Thursday, August 15 from 3 - 6 p.m. and on Friday, August 16 from 1 - 4 p.m. Attendees qualify for five and one-half credit hours of continuing medical education under Category 1 of the Physicians Recognition Award of the AMA. The credit is awarded by the WVU School of Medicine through the Accreditation Council of Continuing Medical Education. The seminar is also acceptable for three prescribed hours as approved by the American Academy of Family Physicians. To register for the seminar, call the WVSMA office at 925-0342.

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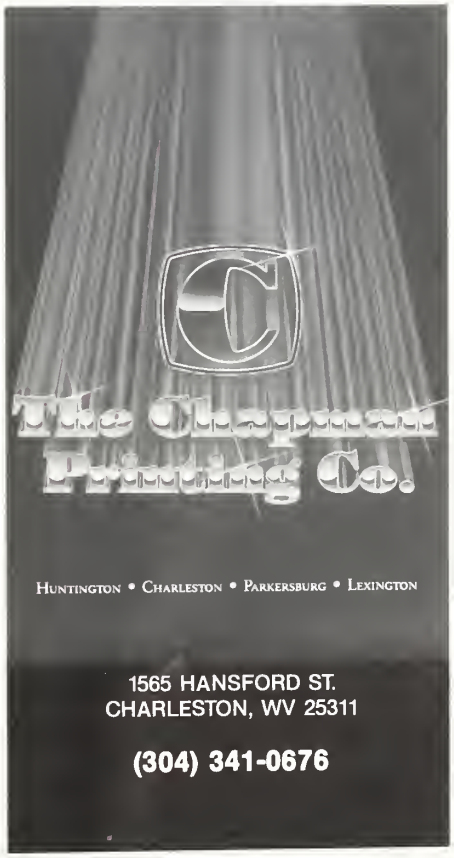

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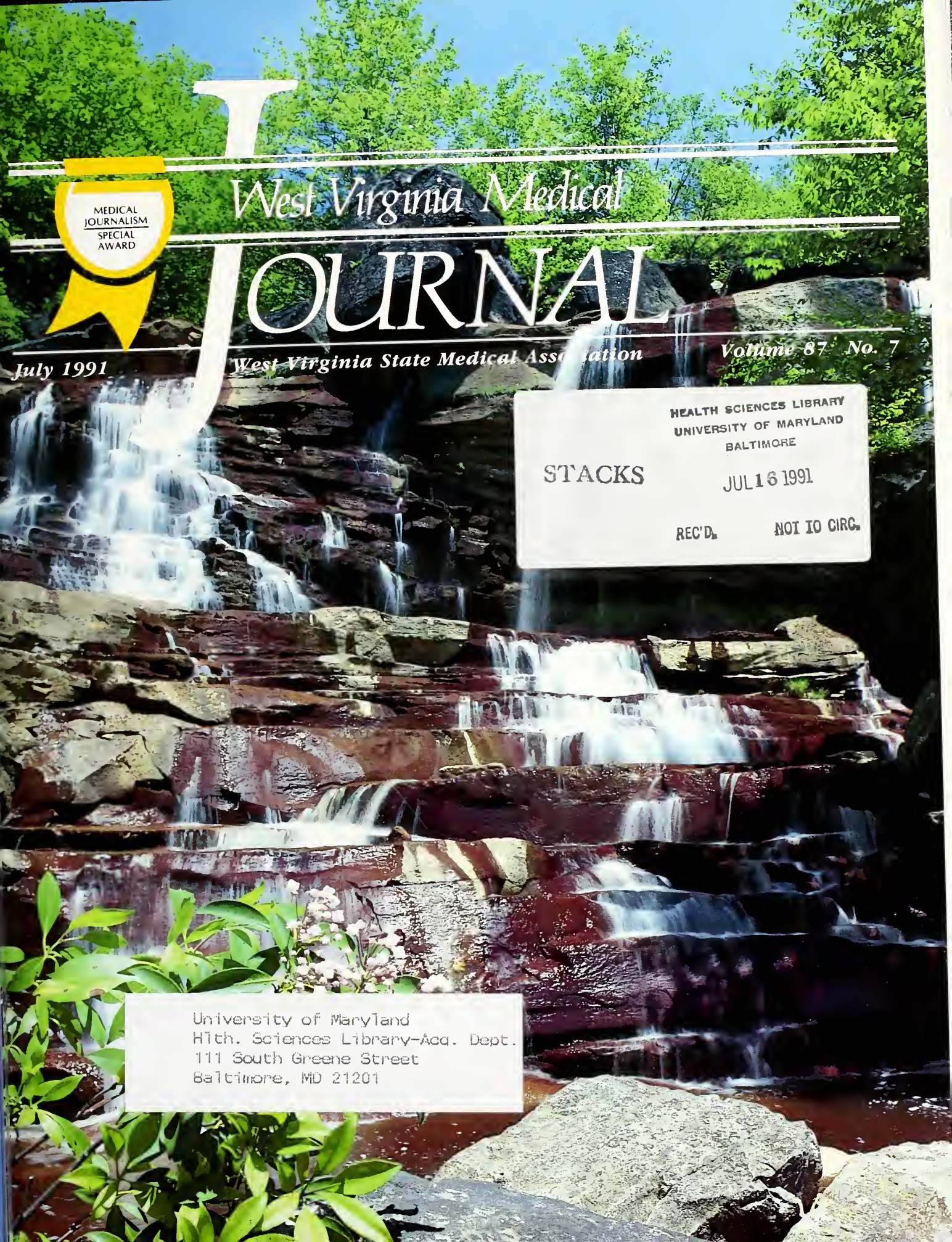
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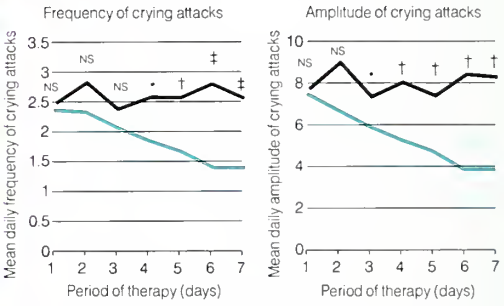

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Pendleton Falls located at Blackwater Falls State Park in Tucker County. Photo courtesy *Stephen J. Shaluta Jr., West Virginia Department of Commerce.*

The Changing Role and View of Physicians

Editor's Note: *The following article contains excerpts from the speech "The Changing Role and View of Physicians" which was given at last year's WVSMA Annual Meeting by Dr. Donald Fidler, an associate professor of behavioral medicine and psychiatry at West Virginia University. This article was prepared for the Journal with special assistance from Dr. Edward Pinney Jr. of Martinsburg.*

To know the greatness of a person, you must not so much view that person, as you must view the people that person touched. To know the greatness of a profession you must similarly view the people that profession touched.

Search the faces and hearts of people we live among and there lie the answers of the successes and the failures of our physicians and health care systems.

Knowledge

Too much knowledge exists for any one physician to know.

The public learns this when they are shifted among specialists or receive wrong answers from physicians who pretend to know it all. What is needed are physicians who can say, "I don't know, but I know where to look it up or to whom to refer you."

Our medical schools lag behind in teaching that there is too much knowledge to know. We should teach students to think and from where to retrieve information instead of forcing memorized data while critical thinking abilities and social skills deteriorate. Patients often see that ugly view: physicians low in social skills, such as not knocking before entering patients' bedrooms.

The shift away from viewing physicians as all-knowing occurred simultaneously as the public became better informed.

Many physicians went into medicine to be like their childhood memories of authority-style physicians, and now battle with modern-day patients, nurses, administrators, lawyers, and insurance regulators.

It was inexpensive to have a doctor say, "You're dying from natural causes." It is expensive to have a doctor say, "We know lots about that; let me send you to four different specialists who practice in intensive care units and premature nurseries with magnetic resonance imaging and liver transplants."

Unlike the transportation industry that did not leap at the chance to send everyone to the moon once sending a person there became achievable, the health industry leaped to practice the philosophy: If it is possible, offer it.

Physicians who had difficulty speaking the old truth: "We cannot help you," rarely speak the new truth: "We cannot afford to help you." That truth sounds equivalent to Eskimos placing seriously-ill elders on icebergs to die, an act our dominating culture once declared "heathen," and yet now we watch Oregon's attempts to ration health care with curious eyes as maturity wakes us to the brutal reality: American Medicine is not limitless in what it can afford.

Rationing must prevail and thus the public will stop viewing physicians as people who lovingly open the doors to health, or even as people who charge dearly to open the doors, and will view physicians as people who guard and ration health. This is how the poor and uninsured now see us. In the future, this is how all patients will see us. We will be like the medicine men of old, healers who help only those who don't require too much from the heart of the universe.

A view that few people see, but a view well seen by public health professionals, is the view that physicians change the genetics of our species by altering what is genetically favored or allowed and encourage the survival of the unfit. The public does believe that physicians coupled with researchers will directly manipulate genes. Fascinatingly, this shifts patients' views of physicians back to the primitive view that physicians are magical and may be doing magic or great evil as we interfere with nature.

Will people admire us or ask government to inhibit us?

Skills

There have been periods in history when healers' skills were perceived as magic.

A sub-group of North Carolina people I interviewed for a documentary on faith-healing believed physicians have evil skills, skills that contradict the courses of God and nature, inviting wrath and condemnation. The majority of people, however, during the past scientific, pre-computer era, viewed medical skills simply as physicians applying knowledge in a straight-forward technical manner, a model in which practice made perfect. People chose physicians who had experience and who were in touch with up-to-date skills. In urban areas, people embraced this view strongest, demanding the most experienced, skillful physicians.

In contrast, in rural and ghetto areas, people were often happy to have anyone help. Medical students were often used as first-line healers.

Improved communication technology taught rural people to demand the same standards of

urban areas, and this "sophistication" along with stricter federal guidelines closed many rural health programs, leaving many rural areas with no health care, resulting in patients traveling great distances to see strangers for health care.

Societies began to envision physicians as resources. Socialistic societies viewed physicians as government resources to be made available to everyone; capitalistic societies viewed physicians as money-making properties to be sold to the wealthy; democratic societies, where citizens can vote to determine what is and is not a "right," voted health "a right."

Business people fought the government people in a "known commodity" war, with many physicians viewing themselves as some sort of human oil wells in high demand with the price of losing autonomy.

Many physicians fought to retain autonomy by trying to act as the business or government leaders themselves; other physicians felt whipped; other physicians settled into being comfortable with being told where, when, and how to practice; and many soon-to-be physicians elected to not even go to medical school, resulting in medical school applications dropping from a 7:1 ratio to a 2:1 ratio in two decades.

If we select and promote mediocrity, the bail out of our medical system will make the Savings and Loan bail out look like play money.

A sign in the office of the president of the University of North Carolina reads, "If you think education is expensive, try ignorance."

In very few medical schools are we adequately teaching students the skills of critical thinking. Faculty are sent to see more patients or to do more funded research in order to support themselves, placing teaching on a back burner.

Availability

In some countries, physicians are only available during banking hours. When evening arrives, physicians bid their hospitalized patients farewell and say a prayer that the patients live through the night. Nature will do what it may, the patients will do what they may, but it is not expected physicians will be available. In the United States, physicians earned the title "residents" by literally living in the hospitals. The norm developed that physicians were always available, even to make house calls when beckoned.

Organization and Compassion

In small tribes or villages, assuring delivery of care required nothing more than a kind heart and lots of work. When knowledge and skills blossomed to create better but more expensive health care, socialistic leaders simply decreed such care unaffordable. (Those leaders often went elsewhere for their own personal care.)

As health care became expensive due to technology and due to the centralization of care in urban areas, the U.S. partially socialized medicine with the creation of Medicaid and Medicare to pay for the care of the poor, the disabled, and the elderly. In a parallel move, American business merged with groups of worried middle-class citizens to create a business version of socialized medicine, insurance programs that paid for health care.

Between the surprises of how much technology and knowledge had elevated the price of health care, coupled with intolerable numbers of physicians abusing these new markets with fradulent claims, Medicaid, Medicare, and insurance companies demanded reform. They dictated this reform with attacks of paperwork and guidelines more complex than even the IRS could design, severely decreasing the efficacy of physicians and requiring the hiring of tens of thousands of middle management personnel, tremendously raising already unaffordable health care costs.

A wide gap developed between the view physicians had of themselves: "Physicians are victims of the government and insurance companies," and the view that the public had of physicians: "Physicians are culprits for charging so much."

While both sides blamed, few examined the unpleasant realities:

(1) Can any society afford medical care for everyone at the level of knowledge and skill that exist?" and

(2) "What is happening in our overall society that people are not healthy?"

Social and Moral Skills

Physicians should have the social and moral skills to either work well in a society or challenge that society to assure success of health care. They must live and thrive within society, be part of their cultures. In a democracy, citizens collectively select what privileges are defined and are not defined as "rights," and may change their minds frequently about these.

Choices can be selected and choices can be reversed.

American medicine is now at an historical point in which citizens or perhaps wealthy citizens will determine whether or not medicine is "a right," and how and to whom it will be delivered.

There have been times in recent history, such as the great revolution in China, where organized medicine was virtually destroyed for several decades, setting back the levels of knowledge and skills. There have been other movements by governments such as Canada and Great Britain to socialize medicine, lowering the quality delivered to the wealthy and raising the quality delivered to the poor.

Now in the U.S. there are also changes. Our government is being overthrown but does not know it. That is because the revolution is not organized. It carries no flag or eloquent speeches.

History teaches that revolutions occur when there is a painfully large discrepancy between the wealthy and the poor. Now, in the U.S., we have the largest gap between the poor and the rich to exist in our 200-year history, maybe a larger, more apparent gap than existed between feudal peasants and robber barons of Europe. We have people who are poor, homeless, without medical care, without nurturance, without proper education. The numbers of these people are staggering. The revolt has begun.

The overthrow of our country presents with warriors who don't even know where to strike. The

revolt presents as child abuse, as sexual crimes, as murders, as gang wars, as political corruption, as military corruption, as banker corruption, as drug abuse, as child neglect, as disrespect for nature, as diffused anger toward communities, as displaced anger toward ethnic groups and genders different from self, as suicide, and as hatred toward self. Make no mistake, such a revolution may be disorganized, but it will topple a society.

Amidst this revolution, it is sad how health care decisions are made. Rather than we physicians educating ourselves and teaching our patients to speak out for what is important in health care, we have succumbed to participating as lobbyists, often falling into the lobbying pitfalls that reduce, blind, and substitute minor issues for important issues, distracting issues such as business-minded territorial wars that have us fighting to keep other professionals from getting paid for their work. When we wish to talk to our own senators and congressmen, we feel we must arrive with large gifts of money to offset opposing lobbyists who also arrive with large gifts of money.

Physicians have choices. We have choices to spend our time and monies on dying people in expensive intensive care units, or spend monies on prenatal care. We have choices to spend enormous hours working in hospitals and clinics, or balance our time by involvement as role models in community activities. We have choices to fight for our poor by having educated voices in government.

We have choices to share our knowledge with the public, with business, and with governments about what makes people sick or healthy. We have choices about practicing preventative rather than only after-care medicine. We have choices to educate people about taking responsibilities in their own health, knowing that 70 percent of health care dollars are spent undoing bad habits and neglect.

When all is said and done, the greatness of nations, institutions, inventions, professions, and art, are ultimately measured not for their ideas or novelty, not for their size or wealth, but are ultimately measured for their total effect upon the human heart and mind, upon the human spirit.

How will we be viewed in our roles as physicians?

Manuscript Information

Manuscripts to be presented for publication in the *West Virginia Medical Journal* should be prepared in accordance with "Uniform Requirements for Manuscripts Submitted to Biomedical Journals" (1) (International Committee of Medical Journal Editors)

The *West Virginia Medical Journal* will not consider for publication a paper or work that already has been reported in a published paper, or is described in a paper submitted or accepted for publication elsewhere.

Manuscripts, accompanied by one copy, should be typewritten, double-spaced, on one side only of white bond paper (8½ by 11 in.), with margins of at least one inch

Use double spacing throughout, including (in the following order) title page, abstract, text, acknowledgements, references, tables, and legends for illustrations. Begin each of the following sections on separate pages: title page, abstract, text, acknowledgements, references, individual tables, and legends for illustrations. Number pages consecutively, beginning with the title page. Type the page number in the upper right-hand corner of each page.

Articles contained on computer diskettes are acceptable and encouraged. Please contact the *Journal* in advance to determine the format type to be used. The conventional manuscript as described above must accompany the diskette.

All persons designated as authors should qualify for authorship. Each author should have participated sufficiently in the work to take public responsibility for the concept.

The second page should carry an abstract of no more than 150 words summarizing the manuscript.

Where reference is made to generically-designated drugs, the first such reference must be followed by parentheses containing the most commonly known trade-name drug of that designation. In addition, a listing of all generic drugs mentioned in the article, with their trade-name equivalents, should appear at the end of the article.

Tables (tabular listings) and figures (photos, drawings and charts) should be numbered and the point of reference in the text indicated in parentheses, i.e., (Table 1), (Figure 1).

Photos must be good-quality unmounted glossy prints usually 5 by 7 in. but no larger than 8 by 10 in. Black and white photos are preferred. Color photos will be printed in black and white. Cost of printing photos in excess of four will be billed to the author.

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Use the style of references seen in this *Journal,* which is based on the formats used by the U. S. National Library of Medicine in *Index Medicus.* The titles of journals should be abbreviated according to the style used in *Index Medicus.* Consult "List of the Journals Indexed," printed annually in the January issue of *Index Medicus.*

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1. Ann Intern Med 1982;96:766-71.

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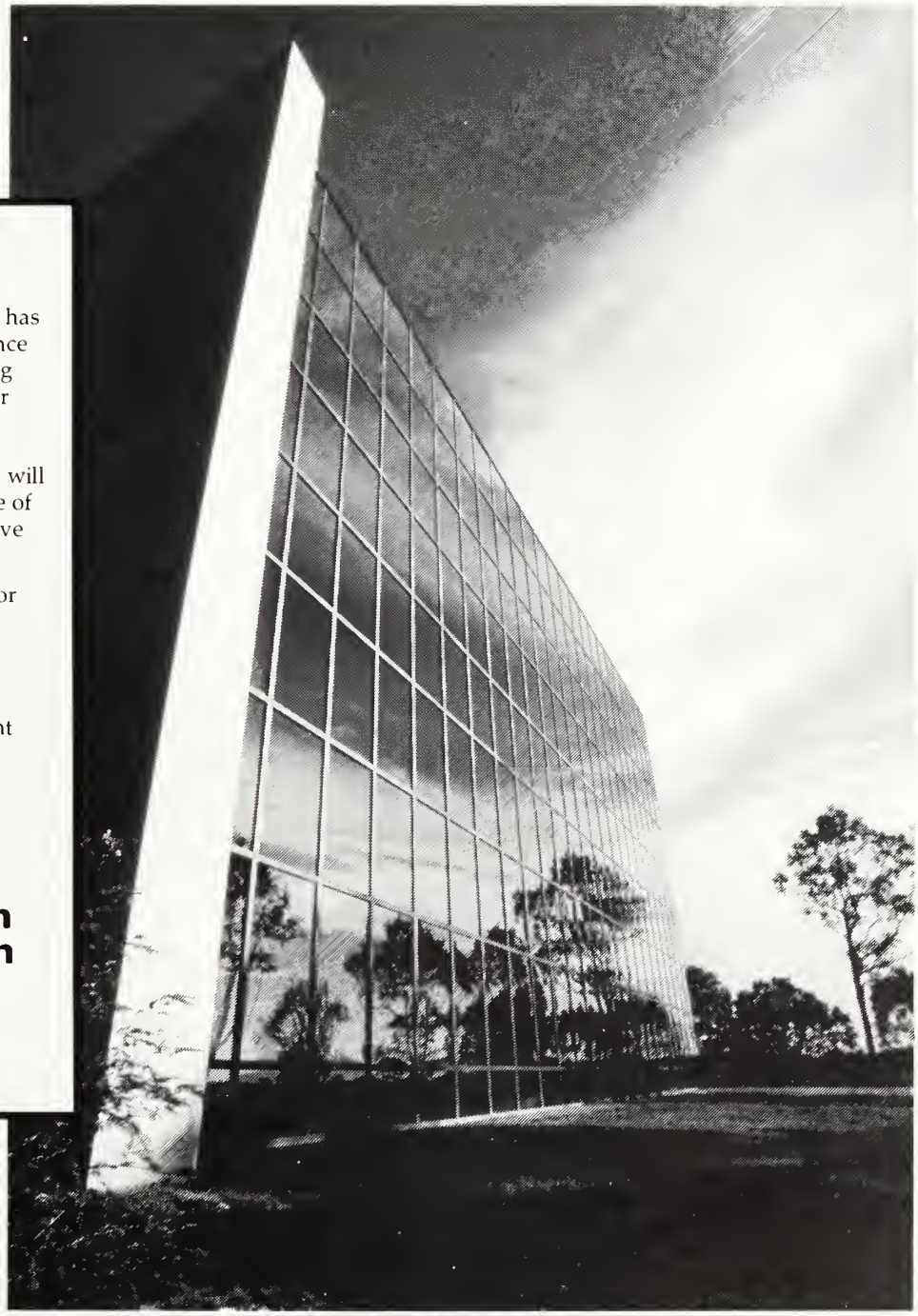

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Adenocarcinoma of the Small Intestine in Crohn's Disease: A Unique Finding

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Abstract

Development of adenocarcinoma of the small bowel is rare. We present this report of a patient with a long-standing history of Crohn's disease who was found to have the 95th reported case of adenocarcinoma developed in the presence of Crohn's. The unique feature of this case is the finding of two distinctly separate carcinomas in the same surgical specimen. With report of this case and a review of the literature, certain characteristics are presented in hopes of raising suspicions sufficiently to detect this malady at an earlier stage.

Introduction

Although it is still relatively rare, the association between small intestinal carcinoma arising in patients with Crohn's disease continues to be reported. Since the first case was reported by Ginzburg et. al. (1) in 1956, 94 cases have been documented. The relationship between adenocarcinoma of the small intestine (ASI) and Crohn's disease (CD) has yet to be statistically proven (2). However, the increasing number of case reports suggests that adenocarcinoma arising in CD may be more than just a chance encounter.

We report the case of a patient with long-standing CD who developed carcinoma of the small intestine. The unique aspect of this case is the development of two distinctly separate types of carcinoma in the same surgical specimen.

Case Presentation

R.E. is a 40-year-old white male with a 12-year history of CD of the distal ileum and colon with chronic peri-anal involvement. He had undergone resection of the terminal ileum and cecum with primary anastomosis and multiple anal incisions and drainage.

The patient was seen in February 1989 for persistence of a peri-anal fistula and underwent exploration where a large inflammatory mass was found in the midline involving much of the jejunum with skip areas to the distal jejunum and proximal ileum. The colon appeared grossly normal and the previous anastomosis was intact. A small bowel resection was performed with approximately five feet of small intestine remaining. The patient had an unremarkable postoperative course and was discharged on steroid therapy. One year following his surgery when this report was written, he was alive and in good health.

Pathology Results

A 65 cm. surgical specimen was examined and showed severe active chronic inflammatory bowel disease with the formation of multiple ulcers extending into the submucosa as abscesses and sinus tracts. A segment of bowel extending 8 cm. in length shows a stenosing, poorly differentiated adenocarcinoma centrally extending approximately 90 percent through the bowel wall but did not involve any of the surrounding fibrous fatty tissue (Figure 1). The majority of this tumor showed a trabecular type pattern. In several areas a nodular pattern was seen with a signet-ring type transformation.

A section examined approximately 5 cm. from the opposite end of the specimen revealed an ulcerated very poorly differentiated adenocarcinoma showing a tubular-type pattern (Figure 2). This tumor revealed a marked fibrous response of the stroma with the neoplasm extending through to the fibrous fatty tissue about the bowel. This tumor showed areas of signet ring-type transformation. Adjacent to this area at the margin of the resection, the mucosa revealed a signet ring-type pattern present in focal islands of tumor. These did not appear to be related to the adjacent ulcerated tumor. Lymph nodes of the attached mesentary showed no evidence of metastatic tumor.

Discussion

This case represents the 95th reported case of small bowel adenocarcinoma associated with Crohn's Disease. The review by Collier et. al. (3) differentiated adenocarcinoma of the small bowel de novo from that of adenocarcinoma arising in Crohn's Disease. These comparisons are based on the current number of reported cases, and although the data is suggestive of true differences, statistical proof is still lacking (due to limited population) (2,4).

The average age of diagnosis of small bowel carcinoma is approximately 65 years. As previously reported, the average age of diagnosis of small bowel carcinoma in CD is approximately 49 years of age (5). Fifty-seven percent of the currently reported patients were 50 years old or less (Table 1) and the largest group of patients fell into the 4th decade.

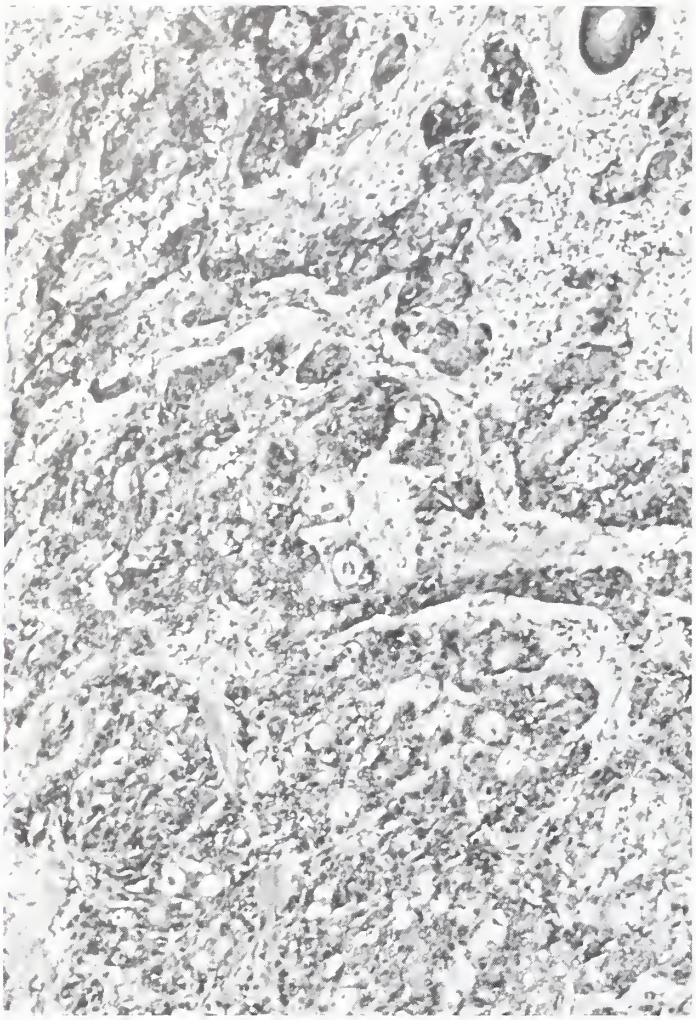

Figure 1. Segment of poorly differentiated adenocarcinoma showing a trabecular type pattern (20X).

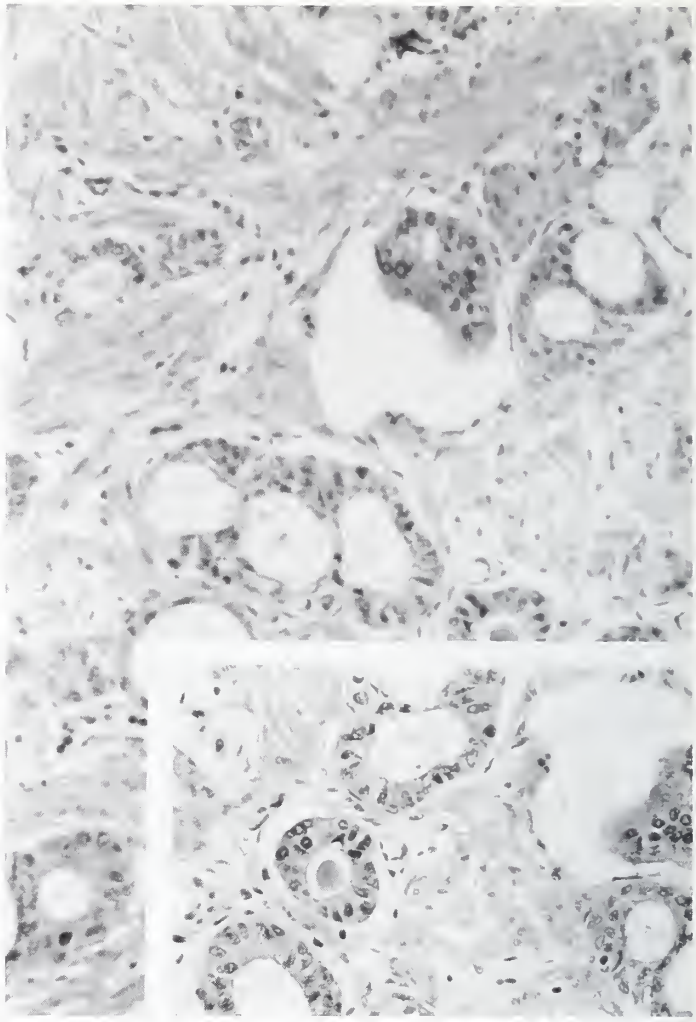

Figure 2. Segment of very poorly differentiated adenocarcinoma showing a tubular type pattern (20X). Inset 40X.

Table 1. Data From Reported Cases

SEX	MALES 70.5%	FEMALES 29.5%	
AGE	>50 42.6%	≤50 57.4%	
DURATION OF DISEASE			
≤10 years	36.5%		
10-20 years	21.5%		
≥20 years	42%		
TUMOR LOCATION			
Jejunum	20%		
Ileum	74.7%		
Both	5.3%		
PRESENTATION			
Obstruction	70%	Mass	10%
Perforation	6.3%	Hemorrhage	5%
Fistula	8.7%		
TIME OF DIAGNOSIS			
Post-op	63%		
Operation	29.8%		
Autopsy	3.6%		
Pre-op	3.6%		
PREVIOUS BYPASS	26.3%		
SURVIVAL >1 YEAR	58.7%		

The predominance of males to females developing ASI in the general population is approximately 1:1 (5). Previously reported male predominance for development of ASI in CD was 3:1, but currently lies closer to 2.41:1 (Table 1).

To date, all carcinomas reported to have developed in small bowel with CD have been adenocarcinomas. The majority of these have been poorly differentiated (6) with well and moderately differentiated lesions found approximately equally. The least reported type is the anaplastic form (3). Approximately 75 percent of the lesions are found in the ileum, 20 percent are found in the jejunum, and the remainder show evidence of involvement in both locations. The location of the lesions roughly parallels the distribution of CD itself, with the majority being found distally (5). This differs from adenocarcinoma of the small bowel found de novo in that these lesions are found more common proximally (7,16,17).

Since it was first suggested by Greenstein that the risk of developing carcinoma was increased in patients with a previously bypassed segment (8,14), bypass is seldom currently performed for CD. It is believed that with bypassed segments there is a delay in diagnosing a carcinoma which may be present. This becomes an important point when considering the idea that duration of disease is an important factor affecting cancer risk (9). The data reported shows a 26.3 percent incidence of previous bypasses in those people developing ASI in CD.

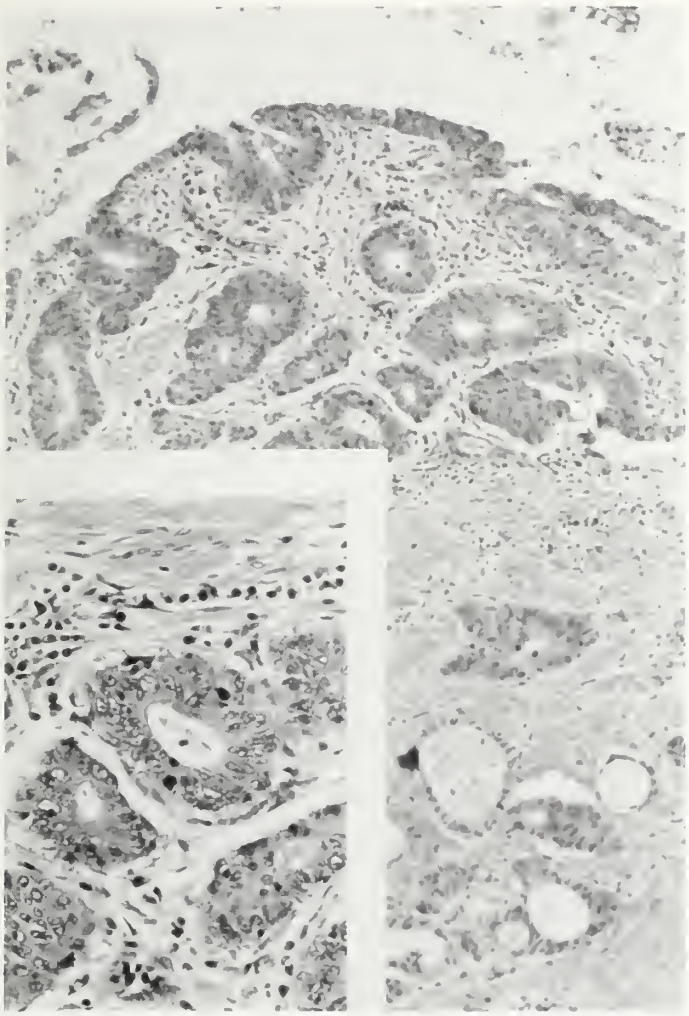

Figure 3. Area of dysplasia adjacent to the segment of tubular adenocarcinoma shown in Figure 2 (10X). Inset 40X.

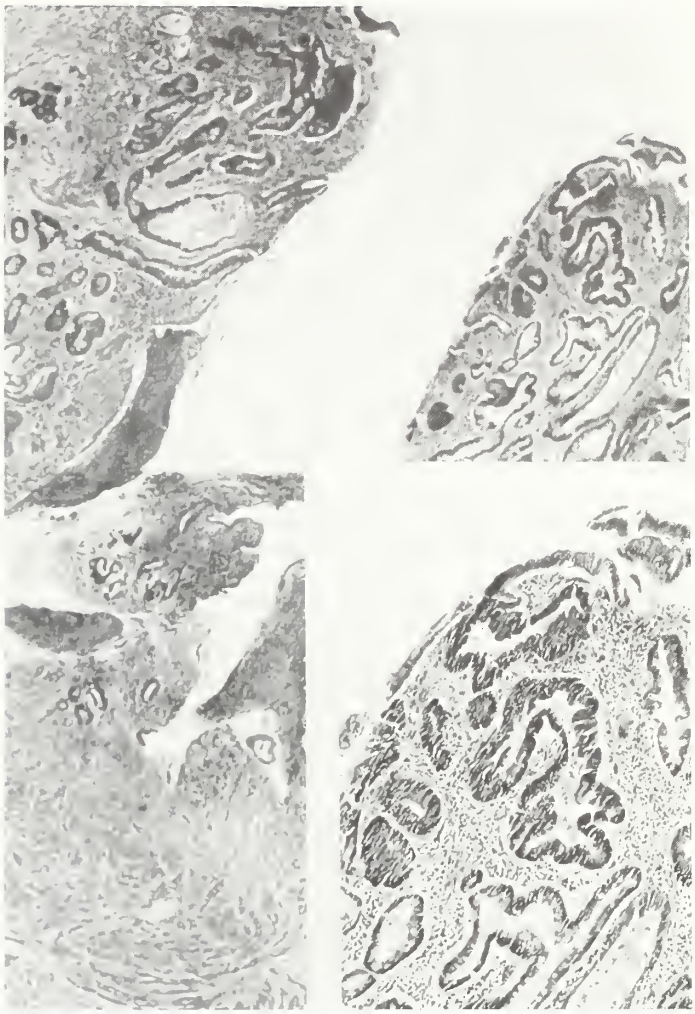

Figure 4. Area of dysplasia remote from the two sights of carcinoma (5X). Inset 20X.

It remains unclear as to the significance of previous bypass, since 74 percent of patients had no bypass.

Diagnosing ASI in CD is clinically difficult since many of the symptoms are attributed to the Crohn's Disease itself (10, 11). Approximately 70 percent of the patients presented with obstructive symptoms. Ten percent presented with a mass, and 8.7 percent presented with a fistula. The diagnosis of the patient which we studied was found postoperatively and was not suspected on gross intraoperative visualization. There has even been report of carcinomatous change occuring in the areas of a fissure (6). It has been suggested that both the presence of a mass and lack of response in healing of a fistula should raise the suspicion for presence of a carcinoma (12,13).

Prognosis for this entity remains poor (5). Due to the difficulty in preoperative diagnosis, most patients harbor a carcinoma with no symptoms separable from their Crohn's Disease. Sixty-three percent of the patients were diagnosed postoperatively on pathologic examination. The five-year survival is less than 10 percent (5). As stated earlier, the risk for cancer and the subsequent prognosis has been suggested to be worse in excluded loops of bowel. This is due to a greater delay in diagnosis possibly leaving a carcinomatous segment in situ for a longer period of time than would be found in a resection (5,9,14).

Epithelial dysplasia is felt by some physicians to be a predisposition to carcinoma (15,18-23). In the present case, sections of dysplasia were found in areas adjacent to the sites of carcinoma (Figure 3). However, dysplasia was also noted at portions of the specimen remote from the carcinoma (Figure 4). In the report by Petras et. al. (18), dysplasia was found adjacent to invasive carcinoma in 10 of 11 patients. They found no areas where dysplasia was noted distant from the carcinoma. Bearzie et. al. (19) did report microfoci of neoplastic tissue in areas removed from the granulomatous lesions as well as adjacent to infiltrating adenocarcinoma. The present case reports two distinctly separate carcinomas, one trabecular and one tubular. These were found approximately 40 cm. removed from each other, with areas of dysplasia noted between them. We show that not only can adenocarcinoma of the small bowel in Crohn's Disease be multifocal in origin, but also may, indeed, be closely associated with dysplasia. (Of particular interest is

the finding of two separate types of carcinoma in the specimen.)

Conclusion

Increasing reports of development of carcinoma of the small bowel in patients with Crohn's Disease continues to add support to the growing evidence that Crohn's Disease may, indeed, be pre-cancerous. Preoperative diagnosis of this disorder remains extremely difficult.

Certain characteristics of the patient's presentation and pathological findings should raise suspicions sufficiently to include adenocarcinoma in the differential diagnosis of Crohn's Disease of the small intestine. Specific characteristics of particular interest appear to be male sex, younger patients with long-standing disease, pathologic specimens found to exhibit dysplasia, possible relationship to previously excluded segments of bowel and presence of a fistula.

Only by raising suspicions in hopes of earlier diagnosis can the current dismal prognosis be altered.

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The Successful Resuscitation of a Hypothermic Multitrauma Patient

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Abstract

Accidental hypothermia due to exposure is an infrequent cause of circulatory arrest. A premature diagnosis of clinical death must be avoided in these patients and vigorous attempts at active rewarming are indicated. Extracorporeal circulation in the form of partial cardiopulmonary bypass has been reported as an effective means of rapid, even core rewarming. We wish to report a recent case at Ruby Memorial Hospital in which extracorporeal circulation was used successfully in resuscitating a profoundly hypothermic multi-trauma victim.

Case Report

A 23-year-old white female who was involved in a single automobile accident in Southwestern Pennsylvania, had been ejected from the vehicle and after approximately five hours was found in subfreezing temperatures by emergency medical personnel. The patient was unresponsive but was noted to have a very weak, slow pulse and no blood pressure. She was transported to Ruby Memorial Hospital by helicopter and enroute warm intravenous solutions were administered. Her vital signs upon arrival were HR-110 BPM, BPS-70mm Hg, RR 24/min. She was unresponsive to verbal as well as painful stimuli. Core temperature was found to be only 27° C.

A rapid primary trauma survey revealed forehead lacerations and an associated open separation of the left fronto-zygomatic suture and fracture of the lateral wall of the left orbit, as well as a nasal fracture. Other injuries included an open, comminuted, transverse midshaft left femur fracture, a midshaft transverse right tibial fracture and a fractured left arm.

Initial laboratory investigations were significant for a hemoglobin of 8.1g/dl., prothrombin and partial thromboplastin times prolonged at 15.5 and 31.0 seconds respectively, and a potassium of 3.4 meq./l. Arterial blood gases after intubation were pH 7.168, pCO_2 26.9 Torr, pO_2 618 Torr, HCO_2-14 meq./l., suggestive of a significant metabolic acidosis. The serum ethanol level was 108 mg./dl. and the urine drug screen revealed the presence of benzodiazepines and cannabinoids.

External rewarming was begun using warming lights and blankets. Simultaneously, internal rewarming was initiated with the administration of heated intravenous solutions, as well as ventilation with warmed gases and gastric lavage using heated fluids. The electrolyte abnormalities and anemia were corrected.

In the operating theater, the femoral vessels were exposed by direct cutdown in the right groin. An 18 Fr. Bard arterial cannula was placed into the right femoral artery and a 19 Fr. Biomedicus venous cannula was placed into the right femoral vein for vascular access. One thousand units of heparin were flushed into the right lower extremity at the initiation of bypass and two hours into the procedure the patient received an additional 2,500 units of heparin systemically.

Initially, the patient's blood volume was passively circulated through a system containing a Biomedicus pump and a SCIMED P-7-14 heat exchanger (Figure 1). However, when the patient fibrillated, the Biomedicus pump was engaged to provide additional circulatory support. The blood flow was maintained between 700-2,100 ml/min. During rewarming the patient fibrillated twice at a rectal temperature of 28° C. ACLS protocol was initiated and with support she was defibrillated successfully and remained in sinus rhythm. Rewarming was discontinued at a rectal temperature of 35° C.

During the rewarming period, a peritoneal lavage was positive and exploratory laparotomy revealed a grade II pancreatic contusion over the midportion of the body of the pancreas, an avulsion of the short gastric vessels and a grade I splenic injury. The splenic injury was repaired with the argon beam coagulator, the pancreatic bed was drained, and the avulsed short gastric vessels were ligated. Intracranial pressure was monitored using a Richmond bolt. Orthopedic surgeons performed a fasciotomy of the right lower extremity and splinted the tibial fracture. The open left femur fracture required open reduction and internal fixation.

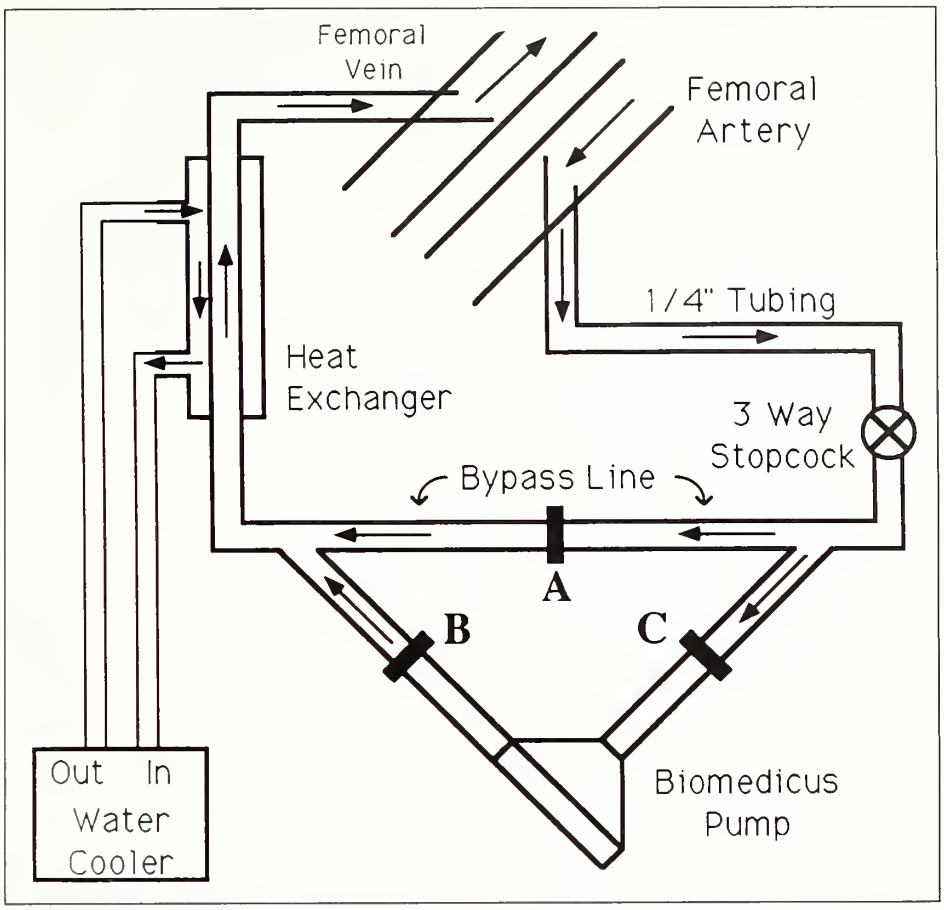

Figure 1. Partial cardiopulmonary bypass can be instituted through this simple system. Clamping line A engages the pump into the system, whereas, clamping points B and C excludes the pump from the system. The three way stopcock allows access to the system for administration of medications or obtaining blood samples.

Following surgery, a CT scan of the head was obtained which showed multiple fractures of the sinuses and orbits. No shifts of the midline structures were noted. After improvement of her neurological and respiratory status, she was extubated on the fourth postoperative day, but on the eighth postoperative day she required reintubation due to probable aspiration pneumonia. She was subsequently weaned from the ventilator successfully after the performance of a tracheostomy. The remainder of her hospital course was uneventful. She was discharged on postoperative day 38 and subsequently seen in the clinic doing well with no permanent neurological deficits.

Discussion

Accidental hypothermia as a result of prolonged exposure to low temperatures occurs more frequently than commonly recognized. It has been reported that up to 80 percent of victims with body temperatures ranging between 24° and 35° C will die if active therapeutic measures are not instituted (1).

A true diagnosis of biological death may be rendered in these patients only after their core temperature reaches 35° C and they fail to respond to any resuscitative measures. Correction of metabolic abnormalities and electrolyte

TABLE 1 Hypothermia levels	
LEVEL	TEMPERATURE (°C)
Normal	36.6 - 37.5
Mild	33.6 - 36.5
Moderate	28 - 33.5
Deep	17 - 27.5
Profound	4 - 16.5

imbalances as well as prompt recognition and treatment of arrhythmias is mandatory in the successful resuscitation of these patients.

Hypothermia is classified by levels according to Reitz (Table 1) (2). Due to the effects of hypothermia in decreasing metabolic and oxygen requirements of the brain and body, patients are able to tolerate physical and metabolic conditions for periods of time which at normothermia would be lethal. At a body temperature of 20° C, the ischemic tolerance of the brain is increased approximately tenfold as compared to tolerance during normothermic conditions.

Signs of life at body temperatures below 27° C are difficult to detect. The patients usually appear motionless and are pulseless with flaccid limbs and fixed, dilated pupils. Resuscitative efforts are usually prolonged and early physical signs of irreversible injury and physiological measurements incompatible with life should be regarded in the context of the tolerance of the patient's hypothermic state, and should not be given the significance of similar findings during normothermia. The literature is replete with reports of successfully resuscitated individuals who have survived periods of circulatory arrest for four to five hours and are well today without permanent neurological injury (1,3).

A variety of methods for treatment of hypothermia have been reported and the appropriate type of rewarming remains controversial (1). Rewarming techniques are divided into either external or internal. External rewarming can be accomplished by warm blankets, head covering, fluid-circulating blankets, radiant heating lamps and increasing ambient temperature. Advantages to this type of rewarming are the simplicity and availability of the necessary equipment. Disadvantages include the development of a "rewarming collapse" which is frequently observed and thought to be secondary to peripheral vasodilation. This rewarming collapse results in hypotension as the heart, which is still cool relative to the skin, has a fixed cardiac output and cannot compensate for the circulatory demand attributed to the increased metabolic demands of the warmer peripheral tissues (3,4).

Internal or active core rewarming can be performed using several different methods:

1) Infusion of warm IV solutions
2) Warming of the respiratory gas mixture
3) Hollow viscous (stomach, bladder, colon) irrigation with warmed solutions
4) Warm irrigation of the abdominal cavity using peritoneal dialysis or lavage of the thoracic cavities via closed tube thoracostomies
5) Extracorporeal blood rewarming using hemodialysis or cardiopulmonary bypass

In the presence of circulatory arrest, the need for rapid active rewarming is mandatory to reverse ventricular fibrillation or asystole. Of all methods for active core rewarming, partial cardiopulmonary bypass (PCPB) can rewarm patients the fastest and provide the most support.

As early as 1967, Davis reported a case of accidental hypothermia treated with extracorporeal bypass for rewarming (5). Since that time, several others have reported the use of PCPB to treat patients with hypothermia (1,3,6,7,8). Partial cardiopulmonary bypass has the following advantages:

1) It can be utilized rapidly under local anesthesia through a groin incision.
2) It is fast.
3) It improves tissue perfusion by using hemodilution (1,11).

This technique also avoids uneven rewarming of the heart by diminishing regional myocardial temperature gradients which could predispose the heart to fatal arrhythmias. It provides circulatory support for known decreased cardiac performance which occurs with rewarming (6). Finally, PCPB has been shown to decrease the incidence of rewarming collapse often seen with surface rewarming techniques.

Indications for use of PCPB include failure to rewarm the patient using other methods and ventricular fibrillation or asystole. Since a core temperature of 30° C is the threshold for successful external defibrillation (6), a temperature below 30° C is an indication for PCPB. In fact, some authors feel that any temperature below 32° C should be treated with PCPB (6). It is well know that the risk of myocardial damage rises with repeated defibrillation attempts at low temperatures (9).

Mortality in accidental hypothermia is associated with ventricular fibrillation and refractory arrhythmias (10). Several factors decrease the fibrillation threshold including hypoxia aggravated by the temperature induced left shift of the oxyhemoglobin dissociation curve, intramyocardial temperature gradients, and acid-base and electrolyte abnormalities (6).

This patient's successful outcome speaks for the slow, even rewarming technique provided by the advancement of extracorporeal circulation. The "bypass" circuit as illustrated in Figure 1 features the Biomedicus centrifugal pump and a simple heat exchanger. As in the case of this patient who initially had adequate cardiac function to intermittently sustain a reasonable blood pressure, the pump can be kept in reserve in an isolated segment of the system ready for use in case the cardiac output becomes inadequate. If faced with having to provide total or partial circulatory support, the pump can be easily routed into the system. The centrifugal nature of the pump allows either no heparin or low dose heparin for adequate anticoagulation. In situations where no trauma has occurred, we have good success using this system to provide partial cardiopulmonary bypass for other indications with only 5,000 units of heparin being

given initially and then following activated clotting times with an upper limit of 200 seconds (12). In the case of trauma, heparin is administered as noted in this report and then the activated clotting time is followed with an upper limit of 150 seconds. Although cannulation in this case was performed by direct cutdown, percutaneous access to the groins provides a reasonable alternative.

An aggressive approach to victims of hypothermia is advocated. Vigorous resuscitative measures are indicated to ensure a favorable outcome. The use of extracorporeal circulation, principally partial cardiopulmonary bypass, provides an effective means of resuscitating victims of hypothermia.

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Fish Stings and Other Marine Envenomations

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Abstract

West Virginia, it would seem, is an unlikely place for physicians to encounter patients with poisonous marine envenomations. To the contrary, West Virginians who vacation at the beach may be envenomated and require further evaluation and treatment when they return home. Likewise, certain aquarium pets or even freshwater fish may envenomate those who have contact with them. Such underwater sea creatures can cause local and systemic toxic or allergic reactions which potentially can be serious. This article describes these possible toxic encounters as well as first aid and medical management.

Introduction

In a landlocked state like West Virginia which is hundreds of miles away from the nearest ocean, the diagnosis and treatment of marine envenomation would be perceived as an unlikely occurrence. However, this perception is no longer true. In fact, health professionals in West Virginia may encounter cases of marine life envenomation for several reasons. Vacationers who go to the beach or scuba dive may incur envenomations that result in prolonged symptoms or delayed reactions. The family physician, therefore, may be contacted by the patient upon return to West Virginia. In addition, physicians are apt to encounter cases of marine envenomation due to the popularity of tropical fish in salt water aquariums. Also, there are certain species of freshwater fish that sting which are native to West Virginia.

*Ms. Bee wrote this article when she was a senior pharmacy student at West Virginia University and did an elective internship at the West Virginia Poison Center in Charleston.

Jellyfish

Some common envenomations incurred by those vacationing on the eastern coast include stings by different jellyfish species. In the Carolinas, the most common species are the cabbage head jellyfish and moon jellyfish. These species do not commonly present a problem to beach combers because they lack long, trailing tentacles. In recent years, however, the sea nettles which are commonly found in the Chesapeake Bay have been migrating south into North Carolina. Also, ebbs and gyres from the Gulf Stream have brought Portuguese man-of-war into the Carolinas when weather conditions are suitable. Both of these creatures have long, trailing tentacles which present more problems beach areas.

Jellyfish envenomation results in two types of reactions — an immediate, toxic reation and a delayed, allergic reaction (1). The venom is stored in an organelle known as a nematocyst which is a thread-like structure that can strike the skin with so great a force that it can penetrate the upper dermis (2).

The toxic reaction occurs just minutes after a sting (1). The clinical presentation depends on such factors as the season, species, number of nematocysts triggered, size of the animal, size and age of the victim, location of the sting, and the victim's health (3). A linear papulovesicular eruption results that resembles poison ivy dermatitis (1). The most common symptoms include severe pain, burning and itching at the site of envenomation (4). Other effects may include difficult breathing, migratory joint pain and enlarged, painful lymph glands (4). Severe reactions include cardiac arrest, respiratory acidosis, respiratory arrest, anaphylaxis and hemolysis (2). These effects are treated with traditional supportive measures. One of the most important aspects of initial treatment is to remove the tentacles to stop further envenomation (2). When rinsing the wound, it is recommended that sea water be

used and that hot water and fresh water not be applied as this may enhance firing of nematocysts (3). Attempts to inactivate the toxin with such substances as acetic acid (5 percent), isopropyl alcohol and papain (a meat tenderizer) have been studied; however, no definite conclusions were made as to which is the most effective method (3). A few studies have revealed that ice or cold packs may relieve pain associated with initial envenomation (4).

Some manifestations of stings may be prolonged and require treatment once the vacationer goes home. For instance, a papular inflammatory skin rash can last for one to two weeks (3). Non-steroidal anti-inflammatory drugs can be used for such a persistent reaction (2). Hyperpigmentation at the site of envenomation can last for several months in which case hydroquinone bleach may be used (2,3). Keloids may also occur and can be treated with corticosteroids (2). Fat atrophy, gangrene, scarring and vascular spasms are other possible chronic reactions (2).

Jellyfish envenomation may result in a delayed allergic reaction which is similar in appearance to erythema nodosum and quite often recurs over a period of several months (2,3). The delayed reaction may be treated with 40-80 mg of prednisone tapered over a two-week period (3).

Stingrays

Another animal which may envenomate those who visit the beach is the stingray. Stingrays are very gentle creatures that are often found partially buried in the sand in fairly shallow water. Stingrays are attracted to gentle movements; however, they become frightened of rapid movements (5). When a person touches or traps the stingray, it lashes its tail forward in defense (5,6). The tail of a stingray has a jagged barb that can inflict puncture wounds or lacerations (6). The barb or spine is also covered by an integumentary sheath and mucus which can contaminate the wound (5,6). Within the integumentary sheath of the barb, there is venom which is released when the sheath ruptures (6).

Most people envenomated by stingrays incur wounds on the lower limbs; however, in some cases a wound can be incurred in the thoracic or abdominal area (6). Stingray barbs are able to penetrate boots, clothing, some boats and in one documented case, a barb penetrated the heart of a 12-year-old boy (6).

Symptoms commonly associated with stingray envenomation include intense, severe local pain which becomes generalized over a period of time (5). Syncope may result due to the severe pain (5). Nausea, vomiting and diarrhea may also occur (5). In severe envenomations or unusual circumstances, convulsions, generalized edema, respiratory distress or cardiac arrhythmias may result (5,7). Local necrosis of the tissue is also likely (6).

The mainstay of treatment is a hot-water soak of the affected area for 30-90 minutes (5,6). Hot water appears to denature the heat labile toxin in the venom (6). Cryotherapy should not be used. The wound should be explored surgically for foreign materials and should be thoroughly cleaned (5,6). Foreign material should be removed, and the laceration should not be sutured but allowed to heal by secondary intention (5,6). Prophylactic antibiotic therapy and tenanus immunization are recommended (6).

Fire Coral

Those who scuba dive in tropical regions can be stung by fire coral, which is not a true coral but is a hydrozoan in the same phylum as the jellyfish. Fire coral is often found growing over other objects in the ocean like coral or sunken vessels and ranges in color from white to yellow-green. Usually mistaken for seawood (3), fire coral has a very sharp lime carbonate exoskeleton, tentacles with nematocysts (3) and small segments which resemble miniature Christmas trees or bushes.

Upon touching the fire coral, one develops an almost immediate burning or stinging which then progresses to an intense, painful pruritus within seconds. Minutes later the person often developes urticarial wheals, redness and warmth in the affected area. The person tends to want to rub the area which leads to further envenomation. Usually within an hour, the wheals are at their peak size and are edematous. The wheals generally flatten within a day or usually abate within a week. However, areas of hyperpigmentation can be present for 1-2 months. Pain associated with the envenomation typically resolves within 30 - 90 minutes. When multiple stings occur, it is possible that painful, inflamed lymph nodes can develop (3).

Treatment for fire coral stings is similar to that for jellyfish stings. The residual dermatitis is generally not severe; however, if a rash is eczematous and indolent, then systemic corticosteroids like prednisone 40-80 mg tapered over two weeks can be used (3).

Aquarium Pets

Marine envenomations in inland areas are rapidly increasing due to the popularity of certain venomous tropical aquarium pets. One of the most infamous of these pets is the lionfish. They typically envenomate by erecting their dorsal fins and piercing the person's skin (8,9).

Studies at the West Virginia Poison Center and others indicate that nearly all lionfish stings were incurred in home aquariums (8-10). The hand or fingers were the site of envenomation in most cases (8).

The most common symptom associated with lionfish envenomation is immediate, intense, sharp, throbbing pain at the site of envenomation which can extend throughout the extremities. Vesicle formation and local swelling that is two to three times the normal size of the appendage is not uncommon (8,9). Chills, nausea, vomiting, diaphoresis, cellulitis, and occasional lymphadenopathy may also result (8,9). More severe systemic effects include paralysis, chest pain, hypotension and arrhythmias (9). Infection, neuropathies, cutaneous granulomas, tissue necrosis/sloughing and indolent ulcers are potential complications (9).

Treatment should focus primarily on alleviating pain, combating effects of venom and preventing secondary infections (11). The affected area should be immersed in hot water for 30-90 minutes (9). Foreign material should be removed, and the wound should be irrigated and cleansed. Supportive measures should be taken for any systemic manifestation. Tetanus prophylaxis should be updated if needed (9). Use of ice for lionfish stings is not

recommended as this may increase local toxic effects (10).

Catfish

Catfish can be freshwater or saltwater in nature; however, the freshwater catfish are native to West Virginia. The catfish usually have one sharp stout spine which extends in front of the other portions of the dorsal and pectoral fins (11). The spines are attached to venom glands which envenomate the victim when the spine punctures the skin (12). When catfish are frightened or injured, a toxin is also secreted by epidermal cells on the skin (12).

The catfish sting causes a rapid, intense throbbing pain or a scalding sensation (11). The pain may be local or it may radiate up the appendage (11,12). Muscle fasciculations can also occur (12). The skin around the wound generally first becomes pale, then cyanotic and finally red and swollen following a sting (11,12). In some instances, swelling may be severe and numbness and gangrene around the wound is possible (11). Bacterial infection by Aeromonas appears to be possible with freshwater catfish envenomation (12). Peripheral neuropathy, wound necrosis and lymphedema are also possible sequelae (12).

Treatment for catfish stings is the same as for other fish stings. In fact, fishermen should consider taking a thermos of hot water with them on their trips. Antibiotic therapy with tetracycline hydrochloride or co-trimoxazole (Bactrim, Roche Laboratories) should also be considered for catfish (12).

In summary, it is important for physicians and other health professionals in inland regions to realize that a potential for fish stings and marine envenomations exists. It is, therefore, important for health care providers to be familiar with symptoms of the stings and commonly used treatments.

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President's Page

Michael M. Stump, M.D.

The GNP and Brainwashing

It is semantic mischief to state that, "Health care now consumes some 12 percent of our Gross National Product," as is frequently done in the various media, including recent editorials in *The Journal of the American Medical Association.*

In any English dictionary, Gross National Product (GNP) means the total value of goods and services produced by a nation in a given time (usually a year). To say that health production consumes x percent of the GNP perverts economics and the true meaning of GNP. Furthermore, it harms a clear understanding of health economics and health costs.

Is this making a mountain out of a molehill? I don't think so. It is necessary to the debate of health care costs to understand the uniqueness of health care contribution to the GNP. The obvious question must be asked, "Why has health care been so successful in increasing its relative and absolute contribution to the GNP?"

Is it because of unique research and development by health care elements?

Is it because of health care's unique competitive and entrepreneurial thrust?

Is it due to very successfully fulfilling a deeper need not previously suspected or not adequately met previously?

Is it overused because government does not tax health benefits of employees as constructive receipt of income?

Or is it being overbought because purchasing individuals do not pay the cost directly?

I also wonder if other contributors to segments of the GNP such as automotive manufacturers and their workers are holding up their end of the contribution.

Have either management or labor become complacent and lost their competitive entrepreneurial spirit?

Are they too unimaginative to bring new ideas to the marketplace or to the workplace?

Are they too shortsighted and stingy to fund necessary research and development?

Is there lack of understanding of global competition, or are either of them too short-term oriented to compete long term?

Or is there such repressive government regulation or taxation that passive investments are better than active investment?

None of these implications may be true but they are certainly just as worthy of consideration as are all the factors and issues concerning health care costs.

In the 1950s, patients directly picked up 66 percent of their health care costs where as now they directly pick up 22 percent. An individual's awareness and knowledge of his/her personal medical costs was certainly far greater in the 1950s than it is today.

Does this cause overutilization of health care and if so how much more?

Is it more optimum utilization?

Is there now a greater desire to stay healthy longer and to use any and all the technology available to accomplish that end?

Does this bring about more health and happiness and if so what is the benefit and what is the cost?

In reality, all costs are ultimately born by individual persons and not by government, business or insurers. The individual is always the payor — it is just a question of how much, how it is paid, where it is paid and to whom. The individual is always the consumer and it is invariably true that an active cost-conscious, benefit-conscious consumer creates the most efficient market known possible that retains the precious freedom of choice.

The growth rate of real GNP of the U.S. since 1961 to the late 1980s has roughly averaged an increase of some 3.1 percent annually, while that of Canada and Japan over the same time has averaged 4.1 percent and 6.2 percent respectively. This is very significant in terms of their total competitive national economic vigor as well as putting into perspective the relatively smaller medical and health service contributions of these countries into their GNP. It is important to investigate and evaluate the origins and causes of the strength of their GNP components and why their GNP growth rate should exceed ours.

Is it possible that if our overall GNP growth rate had equaled their GNP growth rate that all of our health care contribution ratios would have been equal?

The growth rate of GNP is largely a function of labor costs, management systems, investment in research and development, and reinvestment of capital into plant and equipment. In these areas, we often compare unfavorably with other developed nations.

American labor and management have usually maintained an adversarial stance which generally has harmed competitive ability in the capitalistic marketplace since productivity is an essential ingredient in competition.

The U.S. productivity from 1960-1985 increased by 2.3 times, while labor costs increased by 2.4

times. As a result, U.S. productivity significantly lagged behind the 5.4 percent annual productivity growth of 11 major foreign competitors over the same time period. This has effectively cost every U.S. worker some $10,000 to $20,000 in higher living standards per year and probably would not have occurred if both labor and management with governmental encouragement had been mutually cooperative and supportive in serving the long-term best interests of everyone.

Productivity cannot optimally improve until business finances new equipment and factories. The costs of financing these new investments have been far higher in this country than in many other countries because of the cost and availability of capital. It must be a part of the discussion that U.S. interest rates are kept high primarily by our huge federal deficits which devalue the dollar and contribute to inflation. Net interest payments on U.S. debt alone in 1988 were enough to pay for all federal government spending on Medicare, health, and international affairs combined! Needless to say, these payments continue to get larger and larger.

Our huge federal deficits are partially kept high by the continuing transfer of money into "socially responsible" sometimes experimental programs. Due to their economics as well as human impact these programs become a legitimate part of a national discussion. Possibly some portions of the money spent on them might be put to better use on research, development and encouragement of new products and production, as well as with proper oversight of established programs.

Is it possible that the current welfare system discourages employment and that in fact it should be based on a tax credit system that encourages employment? Can anyone deny that some of our financial infirmity could be cured by eliminating or refining programs that carry out past government promises that are not now reasonably in accord with the current national resources, abilities and purposes?

Into this mix, health care expenditures can be properly and proportionally debated. More than 10 million people work in the "health care" industry and in the last ten months, the overall economy has lost some 1,400,000 jobs while the health care industry added some 390,000 jobs.

Is it considered bad to increase employment? In many rural areas, health care is the major employer or among the top employers. Unemployment in rural health care denies significant public access to health care in the rural areas. Is this desirable?

In the world of international trade, U.S. exports of the GNP health care items of drugs and medical products accounted for $11 billion, amounting to a health care trade surplus of $3.2 billion last year. How much should we restrict these initiatives and reduce their contribution to GNP?

We markedly underrate the economic contribution of health care to other areas of the overall economy. Health care contributes greatly to people's economic productivity for themselves as well as their employers. It also contributes to the vigor of a person's body by relieving disease and increasing peace of mind. My own contribution in taxes is manyfold the cost of my fairly considerable personal expenditures for health care.

The American cost-benefit of keeping people healthy and able to work efficiently and effectively has not been adequately studied to my knowledge. It would be interesting to see how close the cost-benefit would come to a zero sum game. The closer this comes to zero or moves to the benefit side, the greater the national importance that must be attached to the problems of labor productivity, management efficiency and governmental debt and policies.

What is the comparative social and economic cost of drug abuse, tobacco, alcohol, sexually transmitted diseases, lack of education and crime?

Are any of these loaded on to the back of health care cost, and if so, is that fair?

Is it possible that we need to examine other facets of our national experience along with our examination of the health care facet?

Is it possible that some of those individuals who have caused us to be so greatly encumbered with debt and stood mute while our educational and social infrastructure deteriorated so drastically, are looking for a scapegoat to direct attention away from even greater problems?

Could it be that the "health care crisis" is but a small part of a far greater national crisis involving loss of confidence by the people in the wisdom, intergrity and vision of our leaders?

As a people, we are a great civilization operating uniquely under a structure of law in a magnificent land that has given us marvelous blessings. I believe many of us would like to explore all aspects of our national existence and determine how we can best get on and fulfill our future.

Along this line of thinking, I want to submit for debate that America can return to greatness by taking the following actions:

(1) by restoring the preeminence of family and individual moral and ethical values;

(2) by reinstating a work ethic to support these values, along with the necessity that welfare shall be a productive and incentive-based system that requires all able individuals to work and learn;

(3) by reestablishing supportive and comprehensive effective education, including appropriate accountability, respect and income for those involved;

(4) by relieving want by assuring availability of employment of some kind for all people all the time; and

(5) by reevaluating and reasserting our national goals and purposes as a people so we may successfully compete in the emerging New World order.

When this debate is completed American health care will be considered a national blessing!

Michael M. Stump, M.D.

Editor's Note: *Dr. Stump recommends the article "A Tax Reform Strategy to Deal with the Uninsured," by Stuart M. Butler, Ph.D., which appeared in the May 15 issue of The Journal of the American Medical Association. Reprints are available by writing to Dr. Butler at the Heritage Foundation, 214 Massachusetts Ave. NE, Washington, D.C. 20002.*

Discount Medicine

The principle provider for delivery of health care in America is the primary care physician: family practitioner, internist and pediatrician. These are generally fee for service physicians who offer their patients time and expertise. If they are not paid for their time, they cannot survive.

RBRVS is a step in the right direction, but before it can be implemented, Medicare cutbacks have cancelled any proposed benefits. Whether by design or accident, current restrictions will soon destroy the private practice of medicine by these groups. I wrote the editorial below in 1988 anticipating much of what has happened since.

In addition, we are told after January 1, 1992, electrocardiograms are worth taking, but not worth reading. Interpretation fees for physicians will be abolished. We must assume that the computer will replace the reader. Computer interpretations of electrocardiograms are notoriously inadequate and frequently incorrect requiring careful overreading by qualified electrocardiographers. Internists spend years in training learning to interpret EKGs, the most important diagnostic tool in heart disease.

The largest medical specialty, internal medicine, once the most sought after medical residency, now serves simply as a springboard to fellowships in more lucrative subspecialties. These bring rewards both professional and financial no longer achievable by primary care internists who practice cognitive rather than invasive medicine. The quality of American medicine is compromised. We are a nation that compensates its physicians for what they do to people rather than what they do for them. Sometimes the best thing is to do nothing.

The problems are compounded in West Virginia. State government, insurance companies, plaintiff lawyers and a litigious climate are factors forcing physicians to leave the state or seek cloistered settings to survive; i.e. government, corporate, or institutional practice.

The state insurance program cannot or will not pay fees except at greatly discounted levels and the governor tells patients it's alright not to pay their medical bills. Blue Cross and Blue Shield are bankrupt. Other insurance companies seem to have policies of "pay no claims" and harassment. UMW now offers to pay with a discount or indefinitely withhold payment. West Virginia is the only state in which there is no prospect for tort reform. Egress of physicians has reached critical levels.

Unless some relief comes, the mounting crisis will worsen. Internal medicine residency programs already report further decline in the percentage of openings filled in 1991. West Virginia is treating doctors poorly and primary care physicians and obstetricians even worse. —JMH

Quo Vadis?

Editor's Note: *This editorial was also written by Dr. John Hartman of Charleston and it appeared in the Journal in May 1988.*

An editorial in the *New England Journal of Medicine,* August 27, 1987, entitled "Why Are Today's Students Choosing High Technology Specialties Over Internal Medicine?" presents a provocative and timely question. The answers are fairly obvious and the response predictable.

Internists, the diagnosticians of the past, used to be referred to as doctors who "know everything and do nothing" in contrast to other specialists. These disciples of Sir William Osler have been held in high regard. Internists no longer enjoy that level of prestige among peers, or self respect, professional fulfillment, patient approval, control of their destinies, or capability to budget time effectively. Nor do they rate a compensatory increase in financial remuneration.

On "Black Tuesday," March 17, 1987, the results of the national internship matching program were announced. This disclosed that top students no longer consider the specialty of internal medicine, in particular, and primary care medicine (family practice and pediatrics) in general, most desirable. This past year technical subspecialties attracted a high percentage of the best students. Cognitive activities such as talking to, listening to, examing and thinking about patients is the most difficult part of medicine and the least financially rewarding. This represents hard physical, mental and emotional work.

Current constraints from many levels — government control, peer review, greedy professionals (in and out of medicine), liability insurance rates, the Medicare freeze, and a litigious society compound these difficulties. In spite of pleas for acceptance of increased compensation for cognitive services, the disparity between payment for these versus procedural and technical skills increases.

Young physicians now more than ever want a family life, time off, professional fulfilment and a reasonably comfortable lifestyle. Primary care physicians, except those in cloistered settings or large groups, find these goals unobtainable. The young are telling us it is time to take a long, hard look at the discrimination against front-line physicians. —JMH

Our Readers Speak

A Vast Difference of Opinion

I am responding to Dr. Wallace's letter, which was also printed in the *Beckley Register-Herald* and the *West Virginia Medical Journal,* in which he attacked my opposition to SB 485, the midwifery bill. I did not originally intend this to be public but feel I have little choice in view of Dr. Wallace's publicity efforts.

What Dr. Wallace terms "bad mouthing," I would call the democratic process. As a taxpayer, I exercised my right to comment on pending legislation. Mine was not the only voice in opposition — both the WVSMA and the Nurse's Association opposed the bill, which was properly defeated. Apparently, Dr. Wallace does not consider either organization his constituency. It is my position that there is a right way and a wrong way to become a doctor. The right way is to go through medical school and be trained; the wrong way is to be appointed by the Legislature.

The bill was written and promoted by radical feminists. They wanted the imprimatur of the Legislature, not only to deliver babies, but to bill Medicaid and other third parties for obstetrical care — they wanted equality with the obstetricians by official decree.

It is fine to assert that all non-routine and complicated cases will be referred, but in practice, obstetrical complications are often unheralded and referral at a late stage is impossible.

Secondly, Dr. Wallace's attitude to the loss of nearly 80 percent of the physicians doing deliveries is that this is a natural phenomenon, like aging. Rather it is a human disease, with the Legislature, the state administration and the legal profession all major pathogens. Our state's loss is another state's gain. Surely, as a public health officer, Dr. Wallace cannot believe in policies designed to drive out the best medical practitioners.

Dr. Wallace states that few obstetricians will practice in rural areas, but the largest obstetrical group in the state is in Beckley. He states that family practitioners are giving up obstetrics, but never examines the role of hospitals, insurance companies and legal profession in forcing these changes.

Regarding House Bill 2461, establishing the West Virginia Health Care Commission, I am pleased that Governor Caperton has appointed Dr. Derrick Latos to the Commission. While the legislation was being debated, the suggestion by the WVSMA that a physician be appointed was opposed by the administration, who led that there were 300 "other" medical groups equally entitled to representation, as if there were no fundamental difference between representatives of organized medicine and Necrophiliacs Anonymous, for instance. It remains to be seen whether this group will accomplish anything. No other states were offered as models for this legislation. I spoke with several of our Raleigh County lawmakers and they had similar reservations that perhaps we were just adding a layer of bureaucracy — "watchers of the doctor-watchers."

I agree with Dr. Wallace that working together is important. Too often, the attitude of the administration and Legislature has been to blindside the medical profession, to be confrontational rather than cooperative. Doctors alone cannot do a lot, but heavy-handed doctor-bashing is equally likely to be counterproductive. Public Health made no progress when it simply described illness — it made great strides when etiologies were elucidated and addressed.

Sincerely yours,

Wallace D. Johnson, M.D.
Beckley

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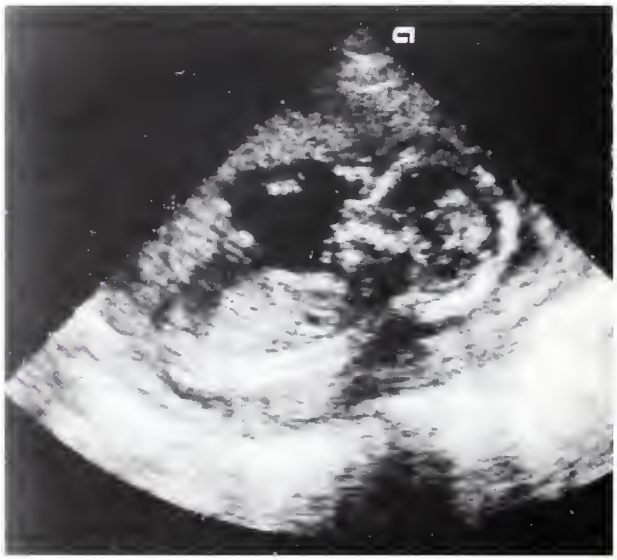

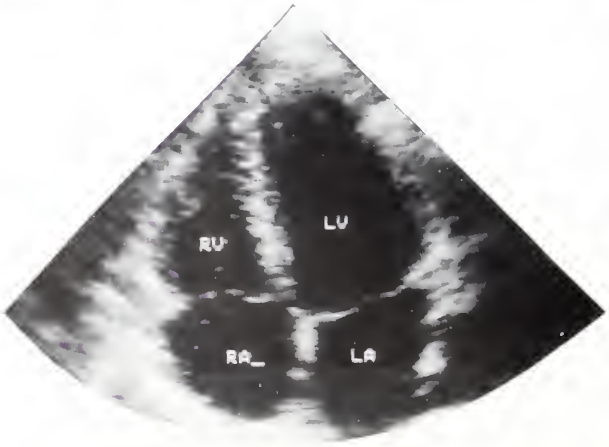

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1991 Annual Meeting

Cancer Update Focus of Second Session

A professor from Vanderbilt University and two department chairmen from the Cleveland Clinic Foundation are the featured panelists for the Second General Session entitled "Update on Cancer Management: 1991," which will begin at 8:45 a.m. on Friday, August 16 during the WVSMA's Annual Meeting at The Greenbrier.

John D. Hainsworth, M.D., associate professor of medicine in the division of oncology at Vanderbilt, is the first scheduled panelist and his presentation is entitled "Non-Small Cell Lung Cancer." The second speaker will be James K. Weick, M.D., chairman of the department of hematology and medical oncology at the Cleveland Clinic Foundation, who will discuss "The Treatment of Breast Cancer." Victor W. Fazio, M.B., B.S., FRACS, FACS, chairman of the department of colorectoral surgery at the Cleveland Clinic Foundation, will conclude the panel with his lecture "Current Management of Rectal Cancer."

Moderator for the panel is Thomas H. Chang, M.D., FACS, a clinical professor of surgery at the West Virginia University School of Medicine who is in private practice in Clarksburg. Dr. Chang is a member of the WVSMA 1991 Annual Meeting Program Committee and serves as chairman of the WVSMA Surgery Section. A Diplomate of the American Board of Surgery and a Fellow of the American College of Surgeons, Dr. Chang is a past president of the West Virginia Chapter of the American College of Surgeons. In addition, Dr. Chang is also a Fellow of the Southeastern Surgical Congress, the American Society of Gastrointestinal Endoscopy, and the Society of American Gastrointestinal Surgeons.

Hainsworth

Weick

Fazio

Chang

Speakers Profiled

Dr. Hainsworth was a National Merit Scholar who graduated from Stanford University in Stanford, Cal., and then received his medical degree from Vanderbilt University, where he also completed a residency in internal medicine and a fellowship in medical oncology.

After finishing his fellowship in 1981, Dr. Hainsworth was appointed to the Vanderbilt faculty as an instructor in medicine in the division of oncology. In 1982, he was promoted to assistant professor of medicine and became director of multidisciplinary oncology at the Outpatient Clinic at Vanderbilt Hospital. The following year, Dr. Hainsworth was named director of the inpatient oncology/hematology unit at the hospital and in 1989, assumed his current role as associate professor of medicine.

A noted author, Dr. Hainsworth has published nearly 200 articles and abstracts. During his career at Vanderbilt, he has received grants from the National Cancer Institute and the American Cancer Society to assist with his research projects.

Dr. Weick is an Ohio native who received his medical degree from Ohio State University in Columbus in 1965 and remained in the city for an internship at Riverside Methodist Hospital. He continued his postgraduate work in internal medicine at the Mayo Graduate School of Medicine from 1966-70, and then went on to obtain an M.S. degree in medicine at the University of Minnesota.

In 1973, Dr. Weick joined the Cleveland Clinic Foundation as a staff physician in the hematology and medical oncology department, which he now has been chairman of for the past eight years.

Active in many professional organizations, Dr. Weick is a member of the American Association for Cancer Research, the American Society of Hematology, and the International Society for Experimental Hematology. He is a Fellow of the American College of Physicians and has published two book chapters and numerous articles and abstracts.

Dr. Fazio received his medical education and completed postgraduate studies in his homeland of Australia. After graduating from Sydney University in 1964, he was a resident for two years at St. Vincent's Hospital in Sydney and became the junior lecturer in anatomy at the University of New South Wales for a year. From 1968-71, Dr. Fazio was a surgical registrar first at Repatriation General Hospital and then at St. Vincent's Hospital, both in Sydney.

Following these three years as a surgical registrar, Dr. Fazio served as a special surgeon for six months in South Vietnam with the Australian Surgical Team. He relocated to the U.S. in 1972 to become a Fellow in surgery at Lahey Clinic in Boston and then joined the medical staff at the Cleveland Clinic Foundation in January 1973 as a Fellow in general surgery. Dr. Fazio was promoted six months later to Special Fellow in the department of colorectal surgery and the next year was named to his current role as a staff surgeon. In addition, Dr. Fazio has been chairman of the department of colorectal surgery since 1975.

Dr. Fazio holds editorial appointments with "Ostomy Management," "Colo-Proctology," and "Diseases of the Colon & Rectum," and has written nearly 250 book chapters and articles.

In addition to his panel presentation, Dr. Fazio will speak on "Current Management of Inflammatory Bowel Disease" at the breakfast meeting of the WVSMA Section on Surgery at 7 a.m. on Friday, August 16.

Good Humor Man, Southwind Band to Entertain at Annual Meeting

Jim Craig, better know as "The Good Humor Man from Missouri," and the Virginia band Southwind, will provide entertainment on Friday evening, August 16 during the WVSMA's Annual Meeting at The Greenbrier.

Jim Craig

Craig has been a keynote or featured speaker at conventions and banquets in 40 states and Canada. Some of the companies he has addressed include Phillips Petroleum Corporation, B.F. Goodrich Company, Southwestern Bell Telephone Company and the Carnation Company.

President of the Better Business Bureau of Southwest Missouri, Craig is the former president and owner of the Credit Bureau in Springfield, Mo., where he currently resides. A graduate of Southwest Missouri State University in Springfield, he is a past president of the school's alumni association and has taught adult education classes at nearby Drury College for 27 years.

Another feature of the evening's entertainment will be the band Southwind, who was obtained by The Greenbrier to play dance music before and after Craig's remarks.

WVSMA ANNUAL MEETING TOURNAMENTS

Golf

Thursday, August 15
noon

Estelito Santos, MD, Chairman

Trophies by Marion Labs

Volleyball

Thursday, August 15
2 p.m.

James Comerci, MD, Chairman

Prizes by WVSMA

Tennis

Thursday, August 15
2 p.m.

William Scaring, MD, Chairman

Trophies by A.H. Robbins

Sign up for tournaments at the WVSMA Registration Desk at The Greenbrier

WVAAFP, Pfizer Labs Sponsor CME Program on Arthritis

The West Virginia Chapter of the American Academy of Family Physicians and Pfizer Labs are sponsoring "1991 Health in Action Day." This event will be held on Wednesday, July 17, from 10 a.m. to 2:35 p.m. at the Kanawha Country Club in Charleston.

The meeting has been designed to offer physicians timely presentations about clinical issues in arthritis and will feature such topics as "Office Management of Osteoarthritis," "NSAID Safety in the Elderly Patient," "Risk Management for Family Practitioners," and "Rheumatoid Arthritis Treatment in the 90's."

The panel of speakers includes Thomas W. Howard, II, M.D., and Michael A. Istfan, M.D. of West Virginia University; Everett N. Rottenberg, M.D., FACP, of the Wayne State University School of Medicine; and Benjamin W. Moulton, J.D., M.P.H., of the Harvard University School of Public Health. John V. Merrifield, M.D., president of the WVAAFP will be the moderator for the scientific session.

The WVAAFP has reviewed and accepted this program for 3.5 prescribed hours by the American Academy of Family Physicians and 3.5 hours in Category I of the Physician's Recognition Award of the AMA.

In addition to the scientific presentations, afternoon golf will be offered by the WVAAFP for a nominal fee of $15, available on a first come, first served basis. Physicians who would like to reserve a tee time may make out a check payable to WVAAFP and return it along with their registration forms which may be obtained from their Pfizer representative. Golf reservations will also be taken on the day of the meeting if there are still tee times available.

For more details or to make a reservation, contact a Pfizer representative or call MetaKnowledge, the symposia planners for the event, at 1-800-552-2157.

National Program Honors Health Care Innovators

To recognize the work being done everyday by health care professionals across the nation, the American College of Physician Executives has announced a program acknowledging individual innovations in health care which is being funded by grants from two national corporations.

The Merck Sharp and Dohme Award will recognize advances in health care quality and will be awarded for the method, technique, procedure or program that has advanced or improved medical, nursing, ancillary or patient satisfaction services.

The Travelers Award will honor improvements in the management of health care costs. It will be awarded for the method, technique, procedure or program that has advanced or bettered the control, containment, or effectiveness of health care cost management.

"There are individuals across the country whose work is achieving lasting, reproducible, and demonstrable benefits for others," says Roger Schenke, executive vice president of ACPE. "These advances could have national impact if they are identified and disseminated."

All entries considered as advances in health care will receive a Certificate of Innovation, national and regional press recognition, and a copy of the manual *Advances in Health Care*. The winners of the two top awards will also each be given one of two Baccarat crystal sculptures imported from France, which will be awarded at the National Awards Program Presentation at the ACPE National Conference. The two recipients will receive a trip for two to the program provided by ACPE.

Anyone who believes they may have demonstrated a way to better the quality of care or manage health care costs is encouraged to enter. Entry deadline is September 3 and forms are available by calling 1-800-562-8088 or writing to The American College of Physician Executives, 4890 W. Kennedy Blvd., Tampa, FL 33609-2575.

Program Links Students, Health Care

Hospitals and health care professionals across West Virginia are helping educators and school children by bringing a bit of the "real world" into classrooms.

The cooperation is a result of Partnerships in Education, a program created and directed by the West Virginia Education Fund which links schools with community organizations and businesses.

"Our main goal is to teach healthy lifestyles and show students what health care is," said Lynn McGraw, education coordinator and a registered nurse at Summersville Memorial Hospital.

In many counties, physicians, dietitians, laboratory technicians, nurses and other specialized hospital personnel visit classrooms teaching children about topics such as healthy snacks, hygiene, blood, birth control and pregnancy issues. Anti-smoking classes like the one conducted for students by Cabell Huntington Hospital highlight the dangers of smoking.

One of the participating health care organizations, Charleston Area Medical Center helps students make career decisions by sponsoring "shadow days" in which students can spend time with a hospital employee in health care, administration, food service or another department. Donna Watkins, director of recruiting at CAMC, said the program is liked so well it has been expanded beyond the assigned school.

Students benefit the hospitals through activities such as visiting nursing homes with skits and cards during the holidays, creating posters and working on fund raisers.

Although financial support is often part of the school partnership, a person-to-person exchange of information is the basic concept of the program. Activities are designed to lower the drop-out rate and promote discipline, good grades and attendance rather than merely provide money.

Students are the main focus of the partnership, but teachers are also a part of this project. Cabell Huntington offers teachers stress management and CPR classes and Humana Hospital-Greenbrier Valley holds "Teachers' Week" to recognize the efforts of teachers.

Physicians Notified of New CME Law

Beginning with the biennial renewal forms submitted to the West Virginia Board of Medicine in 1993, as a condition of relicensure by the Board, all physicians seeking renewal of licensure must be able to document 50 hours of continuing medical education satisfactory to the Board during the preceding two years. This new requirement is a result of a law passed by the West Virginia Legislature in 1991.

Specific information about continuing medical education requirements is contained in the recent mailing from the Board to all physicians who renewed their licenses to practice medicine and surgery as of July 1. Among other items, this mailing contains the proposed rules on continuing medical education, a booklet with the 1991 laws and rules of the West Virginia Board of Medicine (there have been several changes), as well as a new wallet card evidencing current medical licensure.

The Board recommends physicians review the requirements of the law and regulations in all areas as well as reading their booklet, "*West Virginia Board of Medicine Medical Practice Act and Legislative Rules 1991.*" In addition, the Board emphasizes the need for physicians to learn the CME requirements so they will experience no problems at biennial renewal time in 1993, and thereafter.

Multiple Sclerosis Society to Hold Annual Bike Tour

The West Virginia Area Chapter of the National Multiple Sclerosis Society will have its annual MS 150 Bike Tour entitled Go Around The Bend on September 14 and 15 beginning in Charleston at 7 a.m.

This overnight cycling event is sponsored by FM 105 and WOWK-TV 13 to raise money to help fight Multiple Sclerosis.

For more information on MS and the MS 150 Bike Tour, call 1-800-628-5645.

Infections from IVs Up Sharply in U.S.

A recent article in *USA Today* states that infections linked to hospital IVs are increasing rapidly at an estimated cost of $1 billion a year.

According to Dr. Dennis G. Maki of the University of Wisconsin Medical School, the number of U.S. blood stream infections from intraveneous catheters is at least 100,000, double that of what it was a decade ago. Dr. Maki attributes the increase mainly to the fact that the patients are sicker today when they are hospitalized and nearly 75 percent of patients now get IVs versus 25 percent in 1970.

To help stem infections, Dr. Maki reported at a meeting of the American Society for Microbiology about the following new experiments:

► Infection rates were cut in half when hospital workers wore long, sterile gowns and masks, rather than just the standard sterile gowns.

► Infections were cut by 66 percent in 668 patients when a new experimental disinfectant, chlorhexadine, was used instead of iodine or alcohol.

► Infections were cut by 80 percent with experimental, antiseptic-tipped IVs made of bacteria-resistant plastic.

Another report in *The Journal of the American Medical Association,* says coating IVs with antibiotics, using a special bonding material, significantly cuts infections. The method costs just $4.50 more per catheter — vs. about $10,000 to treat an infection.

Gastrointestinal Surgery Topic of Latest NIH Report

The newest consensus development statement from the National Institute of Health is devoted to the subject of "Gastrointestinal Surgery for Severe obesity."

To obtain a free copy of this report, write to William H. Hall, Director of Communications, Office of Medical Applications of Research, National Institute of Health, Bldg. 1, Room 259, Bethesda, MD. 20895.

New Foundation Helps People Sleep

The National Sleep Foundation has been established as a resource center dedicated to provide education, medical referral and research on sleep and its disorders.

As its first educational initiative, the Foundation launched a campaign to address America's most common sleep problem, insomnia, which affects more than 35 million people in varying degrees. A brochure has been printed entitled "When You Can't Sleep: ABC's of ZZZS," and future plans include a variety of educational materials on sleep apnea, narcolepsy, and sleep issues particular to certain age, occupational and disease groups.

"The typical American doesn't see insomnia as a valid medical disorder that warrants professional intervention, and doesn't realize there is real help available," says Thomas Roth, Ph.D., president of the National Sleep Foundation and director of the Henry Ford Sleep Disorders and Research Center in Detroit. "One of our first goals is to correct these misimpressions."

Information and the new brochure are available free by writing the National Sleep Foundation at 122 S. Robertson Blvd., Suite 201, Los Angeles, CA 90048.

WVU Ophthalmology Conference Set

The 12th Annual Ophthalmology Conference sponsored by the West Virginia University Department of Ophthalmology will be held at Lakeview Resort and Conference Center in Morgantown on November 1 and 2.

Ivan R. Schwab, M.D., of the University of California at Davis, will conduct a symposium on cornea and external disease, and Michael W. Gaynon, M.D., of Stanford University, will present a symposium on retina and vitreous disease. In association with the meeting, a contact lens course and a CPT & ICD9 coding seminar are also scheduled for November 1.

Contact Patricia Schumann at 293-3757 for more details.

Physician's Recognition Awards

We wish to congratulate the following WVSMA members who recently received Physician's Recognition Awards from the AMA for voluntarily completing 150 credit hours of continuing medical education during the past three years:

Central West Virginia
Arturo Sabio, Sutton

Eastern Panhandle
Betty Agnir, Martinsburg
John Palkot, Martinsburg
Babulal Pragani, Martinsburg

Greenbrier Valley
Albert Gelderman, Union
Harvey Martin, White Sulphur Springs

Harrison
Chinmay Datta, Clarksburg
Robert Hess, Clarksburg
Jae Kim, Clarksburg

Kanawha
Bharat Agarwal, Elkview
Alberto Lee, Charleston
Jerome Massenburg, Charleston
Richard Rashid, South Charleston
Martin Wershba, South Charleston

Logan
Rano Bofill, Man
Rolando Gellegani, Wilkinson

Marshall
Kenneth Allen, Glen Dale

McDowell
Eugene Kao, Welch

Mercer
Felipe Pia, Princeton
Joel Schor, Bluefield

Monongalia
Timothy Nelms, Morgantown
Edward Stullken, Morgantown

Ohio Valley
George Bontos, Wheeling
John Dorsey, Wheeling
Merrill Wymer, Wheeling

Parkersburg Academy
Gilberto Ramirez, Parkersburg
Lawrence Tarrant, Parkersburg
Laura Toppercer, Vienna

South Branch
Dewey Bensenhaver, Petersburg

Summers
Jack Woodrum, Hinton

Tygarts Valley
Fouad Abdalla, Elkins
James Arnett, Philippi

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Marshall Snedegar
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ENDOWMENT FUND
Building 3, Room 821, State Capitol
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Telephone (304) 348-2771

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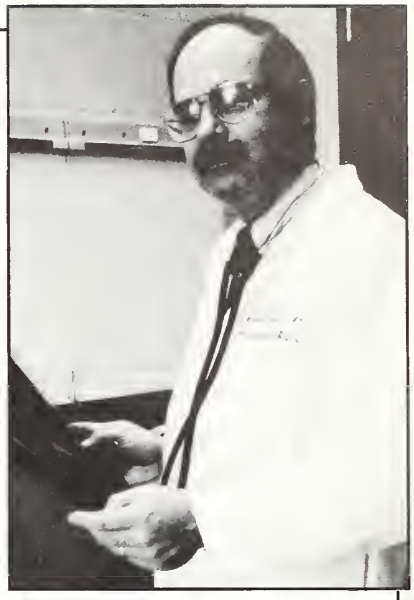

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Continuing Education

Listed on this page are some of the upcoming continuing education programs which will be held throughout the state.

The programs this month were compiled by the following individuals: Patricia Barnhart, WVSMA loss control coordinator; Suzanne Nowell, WVU outreach coordinator of CME; Robin Rector, coordinator of CME for Charleston Area Medical Center; and Thelma Wilson, secretary of the Raleigh County Medical Society.

These programs are tentative and subject to change. Further details about these CME activities may be obtained by calling Barnhart at 925-0342; Nowell at 293-3937; Rector at 348-9580; and Wilson at 255-6341. Other national and state meetings are listed in the Medical Meetings Section of the *Journal.*

This schedule is presented as a convenience for physicians. If you would like to have the continuing education programs offered by your institution or association published in the *Journal,* please contact Nancy Hill, managing editor, at 925-0342.

West Virginia State Medical Association - Charleston

July 27 - WVSMA/CNA Third Generation Loss Control Seminar, Clarksburg

August 14-17 - WVSMA's 124th Annual Meeting, The Greenbrier, White Sulphur Springs

CAMC/WVU Health Sciences Center - Charleston

July 15-16 - "Breastfeeding and WIC: A Healthy Start," Lakewood Resort & Conference Center, Morgantown

July 18-19 - "Breastfeeding and WIC: A Healthy Start," WVU Health Sciences Center Auditorium, Charleston

July 19-20 - "Laparoscopic Surgery for the General and Urologic Surgeon," Women and Children's Hospital, Family Resource Center

Raleigh County Medical Society-Beckley

July 11 - "The Nose and Clinical Allergy," Robert Miller, M.D., Black Knight Country Club, Beckley, 6:30 p.m.

July 17 - "Anxiety and Physical Illness in the Elderly," James M. Turnbull, M.D., Black Knight Country Club, Beckley, 6:30 p.m.

Outreach Programs

Key to Sponsors

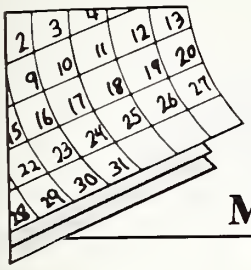
★ WVU Health Sciences Center, Morgantown

☐ CAMC (*)/WVU Health Sciences Center-Charleston (△)

(Check locally for additional information)

Fairmont ★ Fairmont Clinic, July 17, 1 p.m., "Geriatrics: Preoperative Evaluation to Include History and Physical and an Assessment of Risks, David Z. Morgan, M.D.

"Is my warranty still in effect?"



Medical Meetings

July

14-19—16th Annual Meeting National Wellness Institute Inc., University of Wisconsin, Stevens Point, WI.
19-21—National Conference on Breast Cancer, American Cancer Society, Chicago.
20-27—Topics in Contemporary Medicine, (Sponsored by North Memorial Medical Center and University of Minnesota Department of Family Practice, and St. John's Regional Health Center, Springfield, Mo.) Northwest Territories, Canada.
22-26—Association of Philippine Physicians in America, Atlantic City, NJ.
25-August 1—National Medical Association, Indianapolis.
26-27—American College of Medical Quality, Orlando.
27-31—57th Annual Meeting of American Society of Healthcare Executives, Anaheim, CA.
29-31—American Hospital Association, Anaheim, Calif.

August

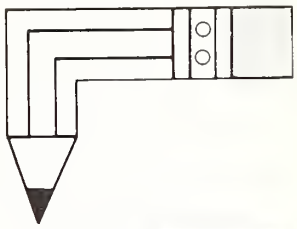
7—Impairing Diseases in Our Colleagues, Families and Patients, Indiana State Medical Association Commission on Physician Assistance, Fort Wayne, IN.
10-16—10th Scientific Meeting and Exhibition of Society of Magnetic Resonance in Medicine, Inc., San Francisco.
10-17—Comprehensive Review in Internal Medicine, Ohio State University, Columbus.
14-17—West Virginia State Medical Association 124th Annual Meeting, White Sulphur Springs.

September

3-8—American Academy of Neurological and Orthopaedic Surgeons, Las Vegas.
5-7—American Gynecological and Obstetrical Society, Carlsbad, CA.
11-13—Administration in Human Service Organizations: The Transition from Clinician to Manager, The Menninger Clinic, Topeka.
12-17—College of American Pathologists, New Orleans.
13—Multiple Sclerosis, Ohio State University, Columbus.
22-27—American Society of Maxillofacial Surgeons, Seattle.
24-27—American Group Practice Association, Honolulu.
26-29—American Academy of Family Physicians, Washington, D.C.

For More Information . . .

Contact the Journal for additional information about most of the above meetings. Call (304) 925-0342.



Poetry Corner

Prarie Woman

(circa 1934)

The next time he comes 'round
I am having it out with him,
Now on the far side of the hard-scrabble field
Plowing up the barren ground.
Rolling thirty gray feet high,
That churning cloud of dust
Envelopes him completely,
Blotting out the sky.
But the sky is too much with me;
The sun bakes the off-field breeze,
Turning it into a hot, dry wind,
A white and broiling dread dead sea.
It's too much to give.
I'll have it out with him
Once and for all.
This ain't no place to live!
I want to live where grass is green,
Where Spring rains wash the sky and earth,
Where barefoot through the flowers
I can wander wet and clean.
Every night in the pillow's cleft
I bury my head
And cry hot tears,
The only juices I have left.
No kids for us
Cause I am dry inside.
We're as dried up as this land,
This hot, parched prarie dust.
Now he has finished the Southeast plot,
Him, the tractor, and the ball of dust.
He thinks he can keep me here;
I'm going to tell him he cannot!
He waves his hat to get my attention.
Handsome he is and brown as an Indian.
Racing through the barnyard with his ploughshares up
And filled with pretension
That he's been an Indian since birth,
And whoopin' it up like one too, I reckon,
If I could hear him over the tractor's roar,
Pounding over the hard-packed earth.
Now He's wavin' his jug.
What was it I was going to do
When he came 'round again?
Oh, yes, take him a fresh jug of water.
Damn!

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- ☐ b. A crystal-ball reader?
- ☐ c. The computer technician?
- ☐ d. Your next door neighbor?
- ☑ e. Your CPA!

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West Virginia Society of CPAs

WEST VIRGINIA UNIVERSITY HEALTH SCIENCES CENTER

Compiled from material furnished by the West Virginia University Health Sciences Center News Service, Morgantown.

WVU, MU Conduct Degenerative Disorders Study

West Virginia University and Marshall University researchers will attempt to contact every person over the age of 65 in Lincoln, Morgan and Tucker counties over the next three years in a screening program to detect degenerative disorders such as Alzheimer's Disease among the rural elderly.

The $3.6 million project, financed by the National Institute on Aging, was announced in early June by U.S. Senator Robert C. Byrd.

Dr. Robert Keefover of WVU's Departments of Behavioral Medicine and Neurology is the program's administrator. He and project director Dr. Eric Rankin will be hiring project managers and interviewers in each county that will visit older residents in their homes and conduct a short screening test. Marshall's part of the project will be coordinated by Dr. Joye Martin of their gerontology program.

West Virginia was chosen as a site for the study because of its largely rural population and the high proportion of elderly people among its residents. The proposal grew out of the recommendations of a statewide task force on Alzheimer's Disease and related illnesses. The task force was initiated by Dr. Michael Lewis of WVU, Dr. Robert Walker of Marshall, and representatives of social service and medical groups serving the elderly in several parts of the state.

The survey is expected to provide a wealth of information about both the prevalence of and risk factors for such diseases among the rural elderly. Effective means of identifying these problems will be developed. Several nationally recognized researchers in the field have contributed to the development of the project, and will take part in its implementation.

Physicians and public health officials in the three counties have been asked to help with the survey and elderly residents will receive free comprehensive screening for these disorders. Project workers will assist people found to be in need of attention contact area medical care providers and social services.

At a second stage of the survey, a selected group of residents will be asked to take part in more detailed diagnostic tests.

The project team is hopeful that 80 percent or more of the older residents of the three counties will participate in the program.

Freshman Scholar Named to All USA Academic Team

Brian Caveney, who will be a freshman Foundation Scholar this fall majoring in chemistry and biology, was one of the 20 high school students in the nation to be named to *USA Today's* fifth annual All USA Academic Team.

Caveney, of Wheeling, is the first student in West Virginia to receive the $2,500 award and he was featured in the May 17 issue of *USA Today*. The prize is in addition to an education and living-expense scholarship, valued at more than $34,000 over four years, that he won as one of five 1991 WVU Foundation Scholars from West Virginia.

The 20 *USA Today* winners from across the country were chosen from 1,651 students nominated by their schools. Judges considered grades, academic honors and leadership roles within and outside school, especially students' use of academic talent beyond the classroom.

D. Lyn Dotson, a member of the WVU Scholars Program Committee, said he is pleased that Caveney, chose WVU. "Most of the 20 students selected by *USA Today* will be at Harvard or Stanford universities next fall," Dotson said. "We're glad that our Scholars Program helped attract such a fine student as Brian to WVU.

Caveney is the second member of his family to receive a Foundation Scholarship. Brian's brother Scott, who just graduated from WVU and is now a freshman in the medical school, won the scholarship in 1987.

Brian plans to obtain a Ph.D. and eventually pursue a career in medical research, possibly with the National Institutes of Health or the Center for Disease Control.

A National Merit semifinalist, Caveney is one of only 30 students in the nation selected this year for the People to People Youth Science Exchange. The group will spend three weeks in China this summer observing and studying traditional Oriental medicine.

Dermatologist Joins Pediatric Faculty

Dr. Nina C. Blumenthal, a board-certified dermatologist, has joined the pediatrics faculty of the WVU School of Medicine.

Dr. Blumenthal will see patients at the Cheat Lake Physicians office in Morgantown and at the Health Sciences Center. Although her primary specialty and teaching responsibilities will be in skin problems of children and adolescents, her practice will include patients of all ages.

Dr. Blumenthal is a graduate of the University of Michigan Medical School, and completed further training at Northwestern University and Wayne State University. She was a clinical instructor of dermatology at Wayne State before coming to WVU.

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MU School Of Medicine News

Compiled from material furnished by the Office of University Relations, Marshall University.

MU to Institute Rural Cancer Project

The Marshall University School of Medicine is launching a new rural cancer prevention demonstration project that is among the first ever funded by the American Cancer Society.

The three-year, $252,000 grant will help identify better ways to prevent cancer in rural people, according to former Governor Cecil Underwood, a member of the board of directors of the West Virginia Division of the American Cancer Society.

"The project is special in that it lets West Virginians help West Virginians," Underwood said. "The American Cancer Society is pleased to make this contribution which will lead to the improved health of citizens of our state."

Dr. Robert B. Walker, chairman of Marshall's Department of Family and Community Health, will head the project, which will focus on the use of cancer prevention and early detection services in Lincoln County.

"Rural Americans often make limited use of programs which can prevent cancers and cancer deaths, and it's essential that we know why so that we can create programs tailored to the needs of rural people," said Dr. Walker. "We can save many years of useful life and prevent a lot of suffering by making proven prevention methods more available and acceptable. Hopefully, we can make life better not only for West Virginians but also for people throughout Appalachia and the U.S.," he added.

Dr. Walker said many factors could cause rural people to use cancer prevention services less than urban people such as economic limitations, transportation problems and lack of access. Other problems, such as fear of a diagnosis of cancer, might be similar to those found in urban areas but require different solutions.

"We may have to take a different educational approach in rural areas because they are so much more personal than large cities," Dr. Walker explained. "Instead of using impersonal media methods, we might find that it's much more effective to encourage local people whose cancer was cured after early detection to speak out."

Project workers will survey Lincoln County residents and medical offices to learn how extensively people are using cancer prevention services. They also will study why these services are not used more often and develop programs which overcome the problems.

According to Dr. Gerald Murphy, an official from the American Cancer Society's national office, the project will help solve the major problem of access.

"Increasing numbers of our fellow Americans are not having access to health care, principally as a result of their being poor," Dr. Murphy said. "This is especially true regarding access to high-quality cancer prevention and early detection services. The West Virginia Division project in conjunction with the Marshall University School of Medicine specifically addresses this concern in a high-risk population."

Dr. Charles H. McKown Jr., dean of MU's medical school, said the project ties closely into the school's rural emphasis.

"Like virtually all of the medical research programs at Marshall, this project focuses on problems of special concern to West Virginians," Dr. McKown said. "We are pleased that the American Cancer Society is joining us in this important effort to improve the health of rural people."

Four Faculty, Six Students Honored at Investiture Ceremony

Four faculty members and six students were bestowed with special awards during Marshall's 1991 Investiture Ceremony.

Seniors inducted Patrick I. Brown, Ph.D., into the Society for Outstanding Instructors and Kevin Yingling, M.D., was named Faculty Clinician of the Year; Lori Bennett, M.D., was given the award for Volunteer Clinician of the Year; and Peter Ottaviano, M.D., was this year's Resident of the Year.

Graduating students given honors were: Jack L. Kinder, Jr., the Bertha and Lake Polan Award for highest academic standing, as well as the Cardiology Award; Steven C. Southern, the Upjohn Achievement Award and the Bettye and Albert Esposito Award; Harry H. Dinsmore, Jr., the CIBA-Geigy Award; Joel T. Hummer, the W. Edwin Black Award; Kevin J. Conaway, the Endocrinology Award; and Jennifer Beth Day, the Gastroenterology Award.

Doctoral Student Given National Award

Daniel Todd, who is pursuing a Ph.D. degree in biomedical sciences at Marshall's School of Medicine, was one of 17 U.S. students honored for their medical research by the American Physiological Society.

Todd received the Procter and Gamble Graduate Student Award and was invited to give a poster presentation on his research at the society's meeting. This presentation was entitled "Identification of a Putative Precursor to Hypertensive Factor (HF) by Monoclonal Anti-HF Antibodies" and is designed to identify a molecule that may be involved in cellular calcium handling and possibly in hypertension.

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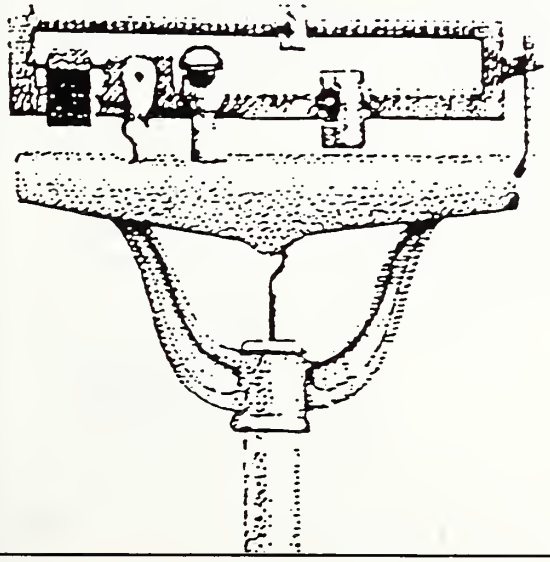

Today, obesity is threatening the lives of more than 39 million Americans, through high blood pressure, diabetes, stroke, heart disease, and many other illnesses. But now, instead of just telling patients to shed a few pounds and then hoping they do it, you can actually help them do it. Refer them to the HMR Weight Management Program at the West Virginia University Health Sciences Center.

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- *Weekly behavioral education*
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WEST VIRGINIA UNIVERSITY
HEALTH SCIENCES CENTER

County Societies

McDowell

Dr. Allen Rosenbloom, an endocrinologist from Bluefield presented a program on "Treatment of Hypertension in Diabetic Patients" at the society's May dinner meeting in Welch.

Also speaking at the meeting was Terri Fritz, executive director of Hospice Care of Mercer County, Inc., who discussed the organization's plan to expand into McDowell County. The society agreed to contribute $350 to help with start-up costs for this effort.

In other new business, Dr. Herland asked members to support Dr. Robert Pulliam of Beckley for vice president of the WVSMA and he presented a letter from Dr. Pulliam concerning his candidacy. Special mention was also made of an article in *Country America* magazine which featured member Dr. David Carr.

Monongalia

The speaker for the May meeting was Dennis Armington, administrator of Mountainview Regional Rehabilitation Hospital.

Following his presentation, Dr. Glover reported on the recommendations of Council and discussed the society's policy on speakers representing or sponsored by pharmaceutical companies. Dr. Glover than read a report on a news item in *PEIA News* aimed at the lay public and urged all physicians to read it. He also commented on L.I.F.E. and recent litigation involving the Omnibus Health Care Act.

In other new business, Dr. Sebert reported on the Managed Care Committee for Medicaid and Dr. Glover commented on recent federal Medicaid legislation as related to the drug industry. The members then agreed to create a resolution regarding the society's support to prescribing the least costly and therapeutically appropriate medication to Medicaid beneficiaries, consistent with the guidelines of the Medicaid formulary. This resolution, if adopted at the society's next meeting, will be presented at the WVSMA's Annual Meeting in August.

Obituary

Donald Painter Brown, M.D.

Donald Painter Brown, M.D., 71, of Kingwood, died May 20 at Heartland of Preston County.

Dr. Brown was born March 26, 1920, in Rowlesburg, and received his undergraduate degree from West Virginia University and his doctor of medicine degree from the George Washington University School of Medicine. He began his family practice in Kingwood in 1946 and retired in 1978, after 32 years of service to the people of Preston County.

A medical officer for the U.S. Naval Medical Corps and Naval Reserves in World War II and the Korean conflict, Dr. Brown was a member of the VFW. He was a member and past president of the Preston County Medical Society and the West Virginia Academy of Family Practice.

Dr. Brown a fellow of the American Academy of Family Physicians and the Southern Medical Association. He was active in community affairs in Preston County throughout his life, serving on the Board of Education, the Board of Directors of Albright National Bank, and as Chief of Staff at Preston Memorial Hospital. He was a member of Rotary International and an active elder and member of First Presbyterian Church of Kingwood.

Survivors include his wife, Yvonne Gallaher Brown of Kingwood; one son, David T. Brown of Kingwood; two daughters, Donna M. Brown of Boone, N.C., and Kim B. Poland of Charleston; two brothers, Charles H. Brown of Kingwood and H. Ben Brown of Seattle; one sister, Mary Lou Stevenson of Marion, S.C.; and two granddaughters.

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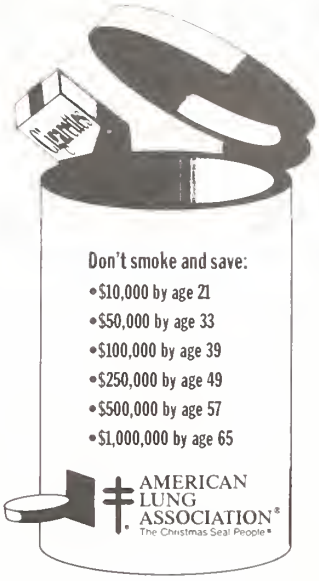

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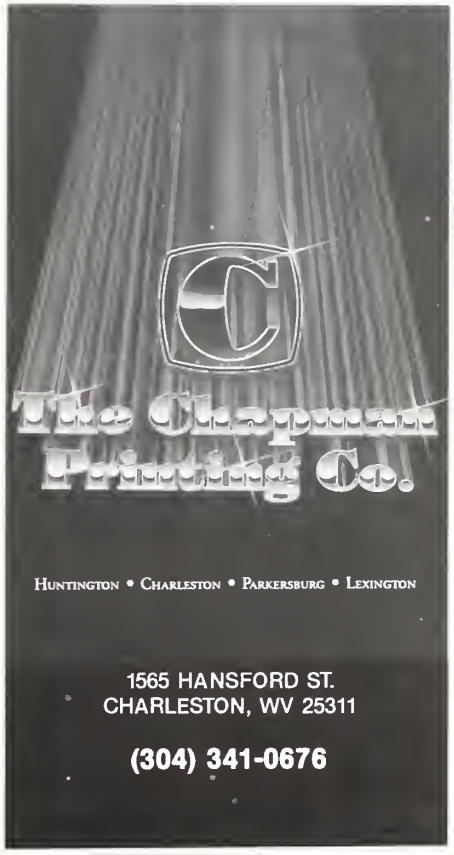

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See adjoining page for brief summary of Cytotec prescribing information.

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Considerations before you prescribe Cytotec

- Because of its abortifacient property, Cytotec should not be prescribed for women who are pregnant. Patients must be advised of the abortifacient property and warned not to give the drug to others.

- Cytotec should be used in a woman of childbearing potential only if she is using effective contraceptive measures, has received oral and written warnings concerning the hazards of misoprostol, has had a negative *serum* pregnancy test within two weeks prior to beginning therapy, and will begin therapy only on the second or third day of the next menstrual period.
- Some patients may experience transient diarrhea, which usually resolves in about a week, or abdominal discomfort. Abdominal discomfort may persist in the absence of gastric ulceration.

BRIEF SUMMARY

CONTRAINDICATIONS AND WARNINGS: Cytotec (misoprostol) is contraindicated, because of its abortifacient property, in women who are pregnant (See *Precautions*.) Patients must be advised of the abortifacient property and warned not to give the drug to others. Cytotec should not be used in women of childbearing potential unless the patient requires nonsteroidal anti-inflammatory drug (NSAID) therapy and is at high risk of complications from gastric ulcers associated with use of the NSAID, or is at high risk of developing gastric ulceration. In such patients, Cytotec may be prescribed if the patient

- is capable of complying with effective contraceptive measures
- has received both oral and written warnings of the hazards of misoprostol, the risk of possible contraception failure, and the danger to other women of childbearing potential should the drug be taken by mistake.
- has had a negative *serum* pregnancy test within two weeks prior to beginning therapy
- will begin Cytotec only on the second or third day of the next normal menstrual period.

INDICATIONS AND USAGE: Cytotec (misoprostol) is indicated for the prevention of NSAID (nonsteroidal anti-inflammatory drugs, including aspirin)–induced gastric ulcers in patients at high risk of complications from gastric ulcer, eg, the elderly and patients with concomitant debilitating disease, as well as patients at high risk of developing gastric ulceration, such as patients with a history of ulcer. Cytotec has not been shown to prevent duodenal ulcers in patients taking NSAIDs. Cytotec should be taken for the duration of NSAID therapy. Cytotec has been shown to prevent gastric ulcers in controlled studies of three months' duration. It had no effect, compared to placebo, on gastrointestinal pain or discomfort associated with NSAID use.

CONTRAINDICATIONS: See boxed *CONTRAINDICATIONS AND WARNINGS*.

Cytotec should not be taken by anyone with a history of allergy to prostaglandins.

WARNINGS: See boxed *CONTRAINDICATIONS AND WARNINGS*.

PRECAUTIONS:

Information for patients: Cytotec is contraindicated in women who are pregnant, and should not be used in women of childbearing potential unless the patient requires nonsteroidal anti-inflammatory drug (NSAID) therapy and is at high risk of complications from gastric ulcers associated with the use of the NSAID, or is at high risk of developing gastric ulceration. Women of childbearing potential should be told that they must not be pregnant when Cytotec therapy is initiated, and that they must use an effective contraception method while taking Cytotec.

See boxed *CONTRAINDICATIONS AND WARNINGS*.

Patients should be advised of the following:

Cytotec is intended for administration along with nonsteroidal anti-inflammatory drugs (NSAIDs), including aspirin, to decrease the chance of developing an NSAID-induced gastric ulcer.

Cytotec should be taken only according to the directions given by a physician.

If the patient has questions about or problems with Cytotec, the physician should be contacted promptly.

THE PATIENT SHOULD NOT GIVE CYTOTEC TO ANYONE ELSE. Cytotec has been prescribed for the patient's specific condition, may not be the correct treatment for another person, and may be dangerous to the other person if she were to become pregnant.

The Cytotec package the patient receives from the pharmacist will include a leaflet containing patient information. The patient should read the leaflet before taking Cytotec and each time the prescription is renewed because the leaflet may have been revised.

Keep Cytotec out of the reach of children.

SPECIAL NOTE FOR WOMEN: Cytotec must not be used by pregnant women. Cytotec may cause miscarriage. Miscarriages caused by Cytotec may be incomplete, which could lead to potentially dangerous bleeding, hospitalization, surgery, infertility, or maternal or fetal death.

Drug interactions: See *Clinical Pharmacology*. Cytotec has not been shown to interfere with the beneficial effects of aspirin on signs and symptoms of rheumatoid arthritis. Cytotec does not exert clinically significant effects on the absorption, blood levels, and antiplatelet effects of therapeutic doses of aspirin. Cytotec has no clinically significant effect on the kinetics of diclofenac or ibuprofen.

Animal toxicology: A reversible increase in the number of normal surface gastric epithelial cells occurred in the dog, rat, and mouse. No such increase has been observed in humans administered Cytotec for up to one year.

An apparent response of the female mouse to Cytotec in long-term studies at 100 to 1000 times the human dose was hyperostosis, mainly of the medulla of sternebrae. Hyperostosis did not occur in long-term studies in the dog and rat and has not been seen in humans treated with Cytotec.

Carcinogenesis, mutagenesis, impairment of fertility: There was no evidence of an effect of Cytotec on tumor occurrence or incidence in rats receiving daily doses up to 150 times the human dose for 24 months. Similarly, there was no effect of Cytotec on tumor occurrence or incidence in mice receiving daily doses up to 1000 times the human dose for 21 months. The mutagenic potential of Cytotec was tested in several *in vitro* assays, all of which were negative.

Misoprostol, when administered to breeding male and female rats at doses 6.25 times to 625 times the maximum recommended human therapeutic dose, produced dose-related pre- and post-implantation losses and a significant decrease in the number of live pups born at the highest dose. These findings suggest the possibility of a general adverse effect on fertility in males and females.

Pregnancy: Pregnancy Category X. See boxed *CONTRAINDICATIONS AND WARNINGS*.

Nonteratogenic effects: Cytotec may endanger pregnancy (may cause miscarriage) and thereby cause harm to the fetus when administered to a pregnant woman. Cytotec produces uterine contractions, uterine bleeding, and expulsion of the products of conception. Miscarriages caused by Cytotec may be incomplete. In studies in women undergoing elective termination of pregnancy during the first trimester, Cytotec caused partial or complete expulsion of the products of conception in 11% of the subjects and increased uterine bleeding in 41%. If a woman is or becomes pregnant while taking this drug, the drug should be discontinued and the patient apprised of the potential hazard to the fetus.

Teratogenic effects: Cytotec is not fetotoxic or teratogenic in rats and rabbits at doses 625 and 63 times the human dose, respectively.

Nursing mothers: See *Contraindications*. Cytotec should not be administered to nursing mothers because the potential excretion of misoprostol acid could cause significant diarrhea in nursing infants.

Pediatric use: Safety and effectiveness in children below the age of 18 years have not been established.

ADVERSE REACTIONS: The following have been reported as adverse events in subjects receiving Cytotec:

Gastrointestinal: The most frequent gastrointestinal adverse events were diarrhea and abdominal pain. The incidence of diarrhea ranged up to 40% but averaged 13% in clinical trials.

Diarrhea was dose related and usually developed early in the course of therapy (after 13 days), usually was self-limiting (often resolving after 8 days), but sometimes required discontinuation of Cytotec (2% of the patients). Rare instances of profound diarrhea leading to severe dehydration have been reported. Patients with an underlying condition such as inflammatory bowel disease, or those in whom dehydration, were it to occur, would be dangerous, should be monitored carefully if Cytotec is prescribed. The incidence of diarrhea can be minimized by administering after meals and at bedtime, and by avoiding coadministration of Cytotec with magnesium-containing antacids.

Gynecological: Women who received Cytotec during clinical trials reported the following gynecological disorders: spotting (0.7%), cramps (0.6%), hypermenorrhea (0.5%), menstrual disorder (0.3%) and dysmenorrhea (0.1%). Postmenopausal vaginal bleeding may be related to Cytotec administration. If it occurs, diagnostic workup should be undertaken to rule out gynecological pathology.

Elderly: There were no significant differences in the safety profile of Cytotec in approximately 500 ulcer patients who were 65 years of age or older compared with younger patients.

Additional adverse events which were reported are categorized as follows:

Incidence greater than 1%: In clinical trials, the following adverse reactions were reported by more than 1% of the subjects receiving Cytotec and may be causally related to the drug: nausea (3.2%), flatulence (2.9%), headache (2.4%), dyspepsia (2.0%), vomiting (1.3%), and constipation (1.1%). However, there were no significant differences between the incidences of these events for Cytotec and placebo.

Causal relationship unknown: The following adverse events were infrequently reported. Causal relationships between Cytotec and these events have not been established but cannot be excluded: aches/pains, asthenia, fatigue, fever, rigors, weight changes, rash, dermatitis, alopecia, pallor, breast pain, abnormal taste, abnormal vision, conjunctivitis, deafness, tinnitus, earache, upper respiratory tract infection, bronchitis, bronchospasm, dyspnea, pneumonia, epistaxis, chest pain, edema, diaphoresis, hypotension, hypertension, arrhythmia, phlebitis, increased cardiac enzymes, syncope, GI bleeding, GI inflammation/infection, rectal disorder, abnormal hepatobiliary function, gingivitis, reflux, dysphagia, amylase increase, anaphylaxis, glycosuria, gout, increased nitrogen, increased alkaline phosphatase, polyuria, dysuria, hematuria, urinary tract infection, anxiety, change in appetite, depression, drowsiness, dizziness, thirst, impotence, loss of libido, sweating increase, neuropathy, neurosis, arthralgia, myalgia, muscle cramps, stiffness, back pain, anemia, abnormal differential, thrombocytopenia, purpura, ESR increased.

Important note: Complete prescribing information should be consulted prior to use.

DOSAGE AND ADMINISTRATION: The recommended adult oral dose of Cytotec for the prevention of NSAID-induced gastric ulcers is 200 mcg four times daily with food. If this dose cannot be tolerated, a dose of 100 mcg can be used. Cytotec should be taken for the duration of NSAID therapy as prescribed by the physician. Cytotec should be taken with a meal, and the last dose of the day should be at bedtime.

Renal impairment: Adjustment of the dosing schedule in renally impaired patients is not routinely needed, but dosage can be reduced if the 200-mcg dose is not tolerated.

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West Virginia Medical JOURNAL

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Front Cover

The historical Spring House on the beautiful grounds of The Greenbrier in White Sulphur Springs. Photo courtesy *Stephen J. Shaluta Jr., West Virginia Department of Commerce.*

Physicians' Medicaid Enhancement Plan

A proposal to tax all physicians was considered but abandoned during the 1991 regular session of the West Virginia Legislature. The idea was to create legislation similar to a bill which would allow certain hospitals to voluntarily contribute to a Medicaid fund in order to capture federal dollars on a better than three-to-one matching basis. The hospital proposal was enacted while the physician proposal was withdrawn.

The physician proposal was dropped because the West Virginia State Medical Association objected to the idea. Important to this process was the invitation by key legislators to meet with the WVSMA Legislation Committee to discuss the proposal. Most important was the agreement by legislators not to push for a bad piece of legislation but instead to try and work with WVSMA to design an acceptable proposal later on in the year.

A Physicians/Medicaid Subcommittee was created in May by the Legislature to design an acceptable plan. It is a subcommittee of the Uncompensated Health Care and Medicaid Expenditures Committee which consists of the following members:

Senate

Joe Manchin III (D), Fairmont
Jae Spears (D), Elkins
William R. Wooton (D), Beckley
Donna J. Boley (R), St. Marys

House

Tom Susman (D), Beckley
John C. Huntwork, M.D. (D), Huntington
Joe Martin (D), Elkins
Bob Ashley (R), Spencer

Citizens

Florette Angel, Youth Coalition Director, Charleston
*Dennis Burton, M.D., Huntington
Glen Crotty, M.D., Charleston
John L. Marks, Medicaid Director, Charleston
*Robert Pulliam, M.D., Beckley
*Stephen Sebert, M.D., Morgantown
*F. Thomas Sporck, M.D., Charleston
*Charles F. Whitaker III, M.D., Parkersburg

*Representing WVSMA

This subcommittee adopted a proposal that has been submitted to WVSMA for approval. The proposal will now have to be approved by the WVSMA House of Delegates when it meets in general session on August 17. It must first be approved by the WVSMA Legislation Committee, Executive Committee and Council prior to the House of Delegates Meeting. If the WVSMA does not approve the measure, the subcommittee will not recommend its passage to the Legislature.

The proposal is to raise Medicaid reimbursements to physicians by obtaining additional federal funds to pay for the increases. With the exception of fees for pediatric and obstetric services, Medicaid fees have not been increased since 1981. The increased federal funds are provided at a rate better than $3 for every $1 of state funds. Another way to look at this is a federal match of 77 cents for every 23 cents the state contributes.

The new Medicaid fees would be established by a physician board and would be set at or near usual and customary reimbursement fees for other third party payers. The new fee schedule would be subject to a tax.

The tax would only be on the states' portion of reimbursement to physicians billing for Medicaid services. The tax will be collected after the new increased fee schedule has been paid to the physician. A guarantee is in the proposal to assure that with the increased fee and the tax, no physician would receive less than the current Medicaid reimbursement schedule.

The proposal calls for an overall increase in Medicaid reimbursement fees from the current 25 percent to 30 percent of usual and customary fees to 100 percent, less the 23 percent tax. This means after the tax, physicians could receive approximately 77 percent of their usual and customary fees.

The legislative proposal contains certain protections for physicians. A special fund would be created in the state treasury and by statute must be used exclusively to increase physician fees for certain office and surgical procedures and to cover the costs of increased utilization due to program growth. Administrative costs would be capped at one percent of the total funds.

The proposal provides for immediate elimination of the tax on providers if the federal or state government makes modifications to the program.

The proposal would also create the Physicians' Medicaid Enhancement Board to develop and review a new Medicaid fee schedule for physician services. The board would consist of seven members with four allopathic physicians, one osteopathic physician, the secretary of the Department of Health and Human Resources, and one lay member. The Governor's selection for each allopathic physician board member would be limited to recommendations submitted by the WVSMA and the selection for the osteopathic physician board member would be limited to recommendations submitted by the West Virginia Osteopathic Society.

According to statistics gathered by the Health Care Financing Authority's Medicaid Bureau, 18 states have hospital or other provider tax or donation programs. Those states are Alabama, California, Florida, Hawaii, Idaho, Kentucky, Maryland, Massachusetts, Missouri, New York, North Carolina, Ohio, Pennsylvania, South Carolina, Tennessee, Texas and Washington. The programs in these states will generate nearly $2.5 billion in federal matching funds in FY 1991.

An additional 17 states and the District of Columbia are planning to implement a hospital or other provider tax or donation program. Those states are Arkansas, Colorado, Connecticut, Indiana, Illinois, Maine, Michigan, Minnesota, Mississippi, Montana, New Hampshire, New Jersey, New Mexico, Rhode Island, Utah, Vermont and Wyoming.

How Would It Work?

- **Physicians currently receive Medicaid payment of about 25-30% of usual and customary fees.
- **A new Medicaid fee schedule would be established based on usual and customary fees.
- **West Virginia would levy a tax on the state share of the physicians' new fee schedule for Medicaid services. Only physicians who see Medicaid patients would be taxed.
- **The money would be put in a special protected fund.
- **The federal government matches the money at a rate of 3.2 ratio.
- **Physicians should receive, after the tax, approximately 77 percent of their usual and customary fees.

Editor's Note: *This entire plan is subject to approval by the WVSMA House of Delegates.*

Abstract: Physician's Provider Medicaid Enhancement Bill

The purpose of the Physician Provider Medicaid Enhancement Bill is to increase access to health care services for indigent persons by providing revenues for increasing the physician fee schedule under Medicaid thus conforming these fees as closely as possible to the provider's usual and customary charges. This is accomplished by taxing the physician provider upon that portion of Medicaid reimbursements exclusively funded by state revenue. These tax revenues are then used to generate increased federal matching dollars. The bill is encapsulated under two separate chapters of the West Virginia Code: Chapter 9, Human Services; and Chapter 11, Taxation.

Chapter 9, article 4-B establishes the Physician Provider Medicaid Enhancement Fund. §9-4B-1 details several legislative findings, while §9-4B-2 lists applicable definitions in the bill. §9-4B-3 establishes the Medicaid Enhancement Board and sets term lengths for each member. The seven member "board" is to be appointed by the governor with the advice and consent of the Senate and shall include: four allopathic physicians nominated by the West Virginia State Medical Association; one osteopathic physician nominated by the West Virginia Osteopathic Society; and one lay person. In addition to these members, the secretary of the Department of Health and Human Resources is to serve as an ex-officio member. Each board member is to be paid $100 per day of board related business plus other reasonable and necessary expenses.

§9-4B-5 details the powers and duties of the board. The board is to develop a physician fee schedule that accurately reflects and conforms to the increased revenues generated by the physician provider tax and the resulting increase in federal matching dollars. The fee schedule is to be submitted for approval to the State Medicaid Agency and is to be reviewed on a quarterly basis.

§9-4B-6 establishes the Medicaid Physician Provider Enhancement Fund in the state treasury. All taxes, interest and penalties collected in accordance with the physician assessments are to be deposited in the fund.

Chapter 11, Article 27 provides the means for the actual imposition of a tax on Medicaid reimbursements. The tax is to be levied on the gross receipts of all physicians and providers in an amount equal to 100 percent of that portion of Medicaid reimbursements derived exclusively from state revenues.

The physician tax is to be administered by the Department of Tax and Revenue in consultation with the Department of Health and Human Resources. The tax is due and payable in monthly installments on or before the 15th day of the month succeeding the month in which the tax accrued. Any provider who fails to pay such tax within 30 days after such tax is due, shall be assessed a penalty of 10 percent on the delinquent amount. Any person who has made an overpayment shall be entitled to a refund.

Any physician who pays the tax as outlined shall be entitled to increased Medicaid reimbursements. At a minimum, these reimbursements are to be equal to 103 percent of the amount of the tax. All provisions of this portion of the bill are subject to the "West Virginia Tax Procedure and Administration Act."

Abstract Prepared By:
Legislative Services
WV Legislature

Editor's Note: *Copies of the Physician's Provider Medicaid Enhancement Legislation will be in the delegates' packets for the WVSMA House of Delegates Meeting.*

WVSMA Staff Members Highlighted

George Rider, Executive Director

Functions as general manager of the WVSMA and oversees all staff functions; prepares and recommends the annual budget with the aid of the finance manager and oversees its implementation; recommends programs to the Executive Committee and Council; works with outside legal counsel; interacts with the media, the Board of Medicine and the various publics; and supervises building maintenance and operations.

Thom Stevens, Associate Executive Director

Works with executive director in overall management of the WVSMA; assumes all functions when executive director is away from office; aides in budget planning and administration; manages WVSMA publications and public communications; supervises non-dues revenue program; directs legislative and governmental programs and outside lobbyists; and staffs the Judicial Commission and the Committee on the Well-Being of Physicians.

Nancie Divvens, Executive Assistant

Assists the Executive Committee in carrying out the policies in the Constitution and Bylaws; functions as office manager and general assistant to the executive director, Executive Committee and Council; coordinates the Annual Meeting and Mid-Winter Scientific Meeting; schedules staff visits to component societies; administers travel policies for educational meetings; and directs two world-wide travel programs for members.

Patricia Barnhart, Loss Control/CME Accreditation Coordinator

Coordinates Physicians' Protection (Loss Control) Program for WVSMA's endorsed carrier CNA Insurance Companies; surveys programs with CME Committee offered by hospitals and various organizations in the state; prepares reports of minutes taken at Executive Committee and Council Meetings; coordinates visits of the president to the component societies; processes contributions to WESPAC; assists in the planning of the Annual and Mid-Winter Meetings; and manages the exhibits at these two functions.

Donna Webb, Membership Coordinator

Keeps dues and informational records on all active, retired and student members; acts as WVSMA's liaison with AMA for membership activities; compiles and creates roster for members; recruits new members; interacts with county societies on membership matters; assists with special projects; updates mailing lists and prepares labels as requested by staff members and other organizations; and answers telephone calls as needed.

Teresa Crouch, Receptionist

Answers telephone calls; coordinates registration for the Annual and Mid-Winter Meetings and Coding and Billing seminars; orders and keeps inventory of office supplies; maintains office equipment; types correspondence for the *West Virginia Medical Journal;* opens and distributes mail; assists with special projects; and runs weekly computer backup of all office files.

Sue Shanklin, Finance Manager

Oversees all WVSMA financial transactions; keeps payroll and employee vacation, sick leave and other records; works with an auditing firm to prepare the annual audit; compiles quarterly tax returns, annual budget and financial statements and presents them to the WVSMA treasurer, Executive Committee and Council; interacts with membership coordinator to process dues; serves on the Finance, Audit and Investments Committees; and obtains proper signatures on all checks.

Dee Crabtree, Government Relations Manager

Serves as executive director of the WVSMA Auxiliary and to WESPAC, the West Virginia Medical Political Action Committee; manages government relations by researching and analyzing legislative issues, lobbying the Legislature, monitoring interim committee meetings, organizing special training and media initiatives, and writing news articles for the *WESGRAM, Medlink* and *Legislative Update;* assists with the WVSMA Legislative Committee; and helps coordinate the Healthy West Virginia Coalition.

Nancy Hill, *West Virginia Medical Journal* Managing Editor

Writes articles, edits all copy, creates the layout and proofreads the pages for the monthly *West Virginia Medical Journal;* works with the editor, public relations/advertising manager and printer on various production aspects of the *Journal;* prepares quarterly *Journal* financial statements for the Executive Committee and Council; serves on the Publication Committee, co-edits and typesets the *WESGRAM,* and assists with other WVSMA publications.

Cindy Hagerman, Public Relations/Advertising Manager

Handles public relations, marketing and communications iniatives by writing news releases, brochures and promotional materials; sells and bills advertising for the *West Virginia Medical Journal,* works with the managing editor of the *Journal* to plan the advertising/editorial content of each issue; designs *Medlink,* the annual patient edition of the *White Paper, Medical Newsline* and other WVSMA publications; serves on the Publications Committee; and maintains the *Journal* subscriptions.

WVSMA Organizational Chart

George Rider
Executive Director

Nancie Divvens
Executive Assistant

Patricia Barnhart
Loss Control/CME Accreditation Coordinator

Donna Webb
Membership Coordinator

Teresa Crouch
Receptionist

Thom Stevens
Associate Executive Director

Sue Shanklin
Finance Manager

Dee Crabtree
Government Relations Manager

Nancy Hill
West Virginia Medical Journal Managing Editor

Cindy Hagerman
Public Relations/ Advertising Manager

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NOTE: A reception, lecture, and cruise have been planned aboard the P. A. Denny Sternwheeler for the evening of September 28, 1991. There is no additional cost for this event.

IL-2/LAK Cell Treatment for Advanced Cancers With Emphasis on a Novel Administration

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Abstract

Interleukin-2 (IL-2) is a substance produced by activated blood cells called helper T-lymphocytes and has been shown to stimulate the body's immune system. IL-2 may cause certain tumors to regress when administered intravenously to laboratory animals and humans. Lymphokine activated killer (LAK) cells are white blood cells that have been stimulated with IL-2 in vitro. LAK cells are capable of killing tumor cells both in vitro and in vivo, especially when given along with IL-2. Although this form of treatment has been found to be effective in patients with certain cancers who no longer benefit from standard forms of therapy, the anti-cancer effects of IL-2/LAK cell treatment are limited by the serious, life-threatening side effects of high-dose intravenous administration, and by the high cost. A treatment program with low-dose, intralymphatically-administered LAK/IL-2 in patients with advanced cancer is a promising alternative which circumvents these major problems and concerns, while maintaining high response rates.

Introduction

Intravenous interleukin-2 (IL-2) with or without lymphokine activated killer (LAK) cells is a form of biological response modifier therapy developed by Rosenberg at the Surgery Branch of the National Cancer Institute which has had promising results in patients with advanced cancer unresponsive to standard treatment. While this therapy has significantly benefitted some patients, particularly those with melanoma or renal cell carcinoma, for most patients with advanced cancer, the toxicity exceeds the benefit. Intralymphatic administration holds the promise of increasing both the safety and efficacy of IL-2/LAK cell therapy.

Progress in the treatment of cancer during the past decade has been due in part to the successful application of different immunological therapies. This treatment is based on biological response modification, and the agents or approaches are referred as biological response modifiers (BRM). BRMs modify the relationship between the tumor and the host by altering the host response to tumor cells.

There are several different types of BRMs used in immunotherapy, including the immuno-modulatory agents (e.g. BCG), the cytokines (e.g. interferons, interleukins, tumor necrosis factor, growth and differentiating factors), tumor vaccines and cellular and humoral adoptive immunotherapy.

This latter form of treatment is one of the most popular areas in cancer research today. Adoptive immunotherapy is the treatment of the host with immunocompetent cells that can destroy tumor cells. The most extensively applied form of adoptive cellular immunotherapy involves the IL-2/LAK cell treatment.

Background

Interleukin-2, once termed the T cell growth factor, permits the in vitro expansion of the number of lymphocytes. A major problem with adoptive cellular immunotherapy has been the limited number of immune cells available for treatment. In addition, while

TABLE 1

Schedule of the Original Rosenberg/NCI IL-2/LAK Regimen

PROCEDURE	SCHEDULE
IL-2: 100,000 U/Kg tid by IV bolus (total dose = 12 MU/m2/day	Days 1-5 (Monday-Friday)
Leukapheresis	Days 8-12 (Monday-Friday)
IL-2: 100,000 U/Kg tid by IV bolus (total dose = 12 MU/m²/day)	Days 12-16 (Friday-Tuesday)
LAK cell infusion IV (average total infused cell# 76 billion/patient)	Days 12,13,15 (Friday, Saturday, Monday)

Rosenberg SA et al, 1985

attempting to expand lymphocytes in vitro using IL-2, Rosenberg and his colleagues determined that a new type of cell (lymphokine - activated killers cell, LAK) is produced which is cytotoxic (both in vitro and in vivo), to many different types of tumor cells, but not to normal cells.

Since the initial reports of these scientists in 1980 on LAK cells (1,2), several important pre-clinical observations have been made:

(a) The maximal cytotoxicity of LAK cells was observed after 3-4 days of incubation with IL-2,

(b) IL-2/LAK cells had more antitumor activity than IL-2 or LAK cells alone,

(c) At higher IL-2 doses, more LAK cell cytotoxicity was observed but there were significantly more toxic side effects, and

(d) Very high, practically intolerable concentrations of IL-2 in vivo were necessary for LAK cell generation.

TABLE 2

Toxicity Associated with High Dose IL-2/LAK Cell Treatment

Toxicity	Frequency (%)
Anemia	98
Eosinophilia over 5%	95
Fever	83
Dyspnea	83
Serum bilirubin over 2 mg/100 ml.	78
Nausea, vomiting	68
Diarrhea	68
Hypotension requiring pressors	66
Serum creatinine over 2 mg%	61
Weight gain over 10% bodyweight	54
Thrombocytopenia	44
Confusion	34
Death	2

Based on these preclinical results, a Phase I clinical trial of IL-2 in combination with LAK cells was initiated at the Surgical Branch of the NCI in 1984 (3). The treatment protocol is outlined in Table 1. The five-day "priming" with IL-2 at the beginning of this program was felt to be necessary to induce a rebound lymphocytosis; thus larger numbers of lymphoid cells could be obtained from the patients with subsequent leukapheresis for LAK cell generation. The cells at a concentration of 1.5 million/ml were incubated with 1,500 units/ml of IL-2 in vitro, then the generated LAK cells were returned to the patients as an intravenous (IV) infusion with concomitant high-dose IV IL-2 at a dose of 100,000 units/kg. High dose IV IL-2 was necessary to keep the LAK cells activated and to achieve the maximal antitumor response.

This treatment was associated with severe toxicity (Table 2). These conditions were usually reversible, mainly due to a "capillary leak syndrome," induced by the high-dose IL-2. The most serious toxic effects included shortness of breath with acute non-cardiogenic pulmonary edema (sometimes requiring mechanical ventilation), confusion, and renal and hepatic failure. The early (or toxic) death rate of this treatment was 2 percent. Due to these potentially severe side effects, the treatments were given in medical intensive care units, which further increased the already high costs of the program.

There have been several modifications since the original Rosenberg trial. Several cancer centers received NCI funding to perform IL-2/LAK clinical studies, the updated results of which are summarized in Table 3. As of January 1989, 121 patients with various advanced cancers had been treated. Complete or partial responses occurred in 35 percent of patients with renal cell carcinoma, and in 21 percent of patients with malignant melanoma. Only about 17 percent of the patients with colorectal carcinoma responded (4).

Due to the toxic side effects and high cost of IL-2/LAK treatment, researchers are investigating more active, less toxic and less expensive forms of treatment. It has been recently reported from Italy that intralymphatic administration of IL-2/LAK requires lower doses of IL-2, with less toxicity and lower cost, but results in excellent tumor response (5). These investigators treated seven patients with previously unresponsive advanced, metastatic tumors. Complete tumor response (disappearance of all clinical and radiological signs of tumor) occurred in four patients and partial tumor regression (50 percent - 70 percent tumor shrinkage) in three. Thus, the overall response rate was 100 percent with no major side effects.

TABLE 3

Results of Modified Rosenberg/NCI IL-2/LAK Cell Regimens (from trials conducted by the NCI Surgery Branch through 3/89)

Tumor-type	Evaluable Patients	Complete Response %	Partial Response %	Response Rate %
Melanoma	72	11	24	35
Renal cell cancer	19	8	13	21
Colorectal cancer	30	3	14	17

Intralymphatic IL-2/LAK Cells

Based on these early results, plans were made by investigators at West Virginia University in Morgantown to study the use of intralymphatic IL-2/LAK cells in patients with advanced cancers. This study, which has recently received FDA and institutional approval, will be undertaken at the new Mary Babb Randolph Cancer Center at WVU.

The objectives of this phase I/II intralymphatic IL-2/LAK cell study are:

(1) To determine the maximum tolerated dose (MTD) of IL-2/LAK cells administered by the intralymphatic route,

(2) To evaluate the safety and determine the toxicity of intralymphatic IL-2/LAK cells in patients with advanced cancer (phase I), and

(3) To determine the antitumor response of intralymphatic IL-2/LAK cells (phase II).

Based upon published preliminary data, it is likely that responses will

be observed before the maximal tolerated dose is achieved. The minimum response rate (CR plus PR) of interest is 30 percent. Plans are to recruit 35 eligible patients within about 2 years.

Three days prior to the intralymphatic IL-2/LAK cell treatment, 100 ml of peripheral blood is obtained from the patient for the in vitro generation of autologous LAK cells. The lymphocytes are separated and washed in serum-free medium. Recombinant Interleukin-2 (Hoffman LaRoche Corporation) is added and the mixture is incubated for 48-72 hours at 37°C in a CO_2 incubator to produce LAK cells. The LAK cells are washed and resuspended in saline containing IL-2 for intralymphatic administration. LAK cells will be administered only if they are able to achieve a threefold increase in their ability to kill a standard tumor cell line. All pilot LAK cell lots tested thus far have exceeded the threefold increase.

Patients with advanced measurable malignancy (solid tumor) who have failed other accepted forms of cancer therapy are eligible for consideration for intralymphatic IL-2/LAK cell therapy. All patients must have histologically confirmed advanced cancer and not be expected to benefit from conventional treatment modalities. They must be at least 18 years of age, ambulatory and with a life expectancy of at least four months. Their organ function must be adequate as indicated by a white blood cell count of $\geq$ 3,000/mm^3, a platelet count $\geq$ 100,000/mm^3, hemoglobin level > 9g/DL (may be transfused to achieve that level), normal bilirubin level and a creatinine level $\leq$ 3.0 mg/dl. In addition, individuals for the study must have no evidence of congestive heart failure, symptoms of coronary artery disease or evidence of prior myocardial infarction. Single Breath Diffusion Capacity (DLCO) must be at least 50 percent, and forced expiratory volume >2.0 liters.

Patients must give signed informed consent before treatment is started. They will be excluded if they have infections requiring antibiotics, HIV, Hepatitis, organ allografts, or primary or metastatic brain cancer. In addition, these individuals must not have received chemotherapy, hormonal therapy, immunotherapy (LAK), or radiotherapy within the previous four weeks, or cytokine therapy (interferon, IL-2) within the previous 8 weeks. Those who received radiotherapy to a non-evaluable lesion may still be eligible. Pregnant patients are also ineligible, and women of childbearing age must take precautions to avoid pregnancy while on this protocol.

Patients may be removed from the study for intercurrent illness, unacceptable toxicity in the absence of an objective response, or changes in their medical condition which render them unacceptable for further treatment. They will receive treatment with intralymphatic IL-2/LAK cells at intervals of 3-4 weeks and treatment may be repeated until progressive disease develops or the criteria for the removal from study are met. The dose of IL-2 may be increased for patients who have stable or progressive disease if significant toxicity has not been observed. The dose of the IL-2 will be 10,000 U/M^2 initially, and then increased until the maximal tolerated dose is reached (not to exceed 160,000 U/M^2). At least three newly entered patients will be treated at each dose level. Every patient will be evaluated after each treatment for tumor regression and toxicity.

It is expected that this treatment will have significantly less side effects than those described in Table 2 and (5). Patients will be observed for at least 24 hours following the administration of IL-2/LAK cells at Ruby Memorial Hospital. If the lymphatics of the feet cannot be cannulated, LAK cells and IL-2 will be infused intralymphatically through the lymphatics of the hand, subcutaneously, or into accessible draining lymph nodes. Patients who cannot be treated by protocol-approved routes may be eligible for this treatment on a compassionate basis.

It is hoped that this treatment will help to improve the quality of life and perhaps the survival of patients with advanced cancer.

Acknowledgements

Technical assistance for this article was provided by Linda Anderson and Kathy Watkins. Funding for the project was provided by Mary Babb Randolph Cancer Center at West Virginia University in Morgantown.

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Medical Grand Rounds

West Virginia University Health Sciences Center

Osteoporosis

Discussant:
IRMA ULLRICH, M.D.
Professor of Medicine, Section of Endocrinology/Metabolism

Abstract

Osteoporosis is an important medical condition which is expensive in morbidity and mortality. Type I osteoporosis affects women 10-15 years after menopause and involves primarily trabecular bone while Type II, senile osteoporosis, results in hip fractures in both sexes.

Lifelong calcium intake and physical activity affect peak bone mass and are instrumental in prevention of osteoporosis. Therapy with fluoride, vitamin D, androgens and diphosphonates have been studied and their results and side effects are reviewed.

Introduction

As our population ages and becomes more sedentary, osteoporosis and its complications involve increasing numbers of people. Although its distribution is worldwide, there are regional differences in occurrence. Over age 65, 10 percent-15 percent of the population has osteoporosis; by age 75 nearly all women have bone mineral density which is below the fracture threshold for hip fractures (1). By age 90, 32 percent of women and 17 percent of men have had hip fractures with up to 20 percent dying of complications. It has been estimated that osteoporosis accounts for 70 percent of the one million fractures which occur annually.

Risk Factors

Risk factors include age, small stature, smoking, low calcium intake, excess alcohol consumption and a sedentary lifestyle. Hyperprolactinemia, anorexia nervosa and athletic amenorrhea are all associated with decreased levels of estrogens and excess bone calcium loss. Also, poorly controlled Type I diabetes mellitus results in increased loss of calcium in the urine. Steroids are an important cause of osteoporosis in those treated with pharmacologic doses for an extended period of time. Heparin and antinconvulsants have also been associated with loss of calcium from bone.

Clinical Presentation

The female patient with osteoporosis usually comes to medical attention in one of two ways. She may have the acute pain of a compression fracture or the more chronic syndrome of a backache. The areas of the skeleton involved most often are the spine, hip and the forearm. Vertebral body fractures are compression fractures which occur with minimal or no recognized trauma. Coughing or straining or lifting a light object may result in acute compression with pain in the area associated with paravertebral muscle spasm. These fractures wedge anteriorly, so nerve roots because of their posterior location are not usually injured. Compression fractures are most frequent in the lower thoracic area (T 10-12) and upper lumbar area. Next most common are fractures above or below those areas. Although any area of the back may have a fracture, the cervical and upper thoracic vertebrae are rarely involved.

The pain of an acute fracture usually responds to analgesics and 2-3 weeks of bed rest. This acute syndrome may be followed by a more chronic backache which is made worse by prolonged standing. Multiple fractures which are either clinically apparent or asymptomatic usually result in kyphosis. If the kyphosis is severe, the abdomen is protuberant and the ribs may nearly rest on the pelvic brim. In this circumstance, much of the chronic aching may be due to poor posture and may respond to appropriate extension exercises. This deformity obviously also presents cosmetic problems.

This clinical presentation has also been termed vertebral crush syndrome or Type I osteoporosis (2). Ninety percent of cases are in women 15-20 years after menopause. Vertebrae are mostly trabecular bone. Forearm fractures, the Colles' variety, are also common in this group with the fracture occurring in primarily trabecular bone in the wrist.

The femoral head and neck are the sites involved most often after the spine. Most of these fractures occur in people over 70, and the ratio of women to men is 2:1. Although the fractures may be treated with nails or protheses, 50 percent of patients never regain full independence and 15 percent or more die of complications. This second category has been termed Type II or senile osteoporosis. It occurs in persons 70 years or older. In hip fractures, there has usually been some sort of trauma such as a fall from at least standing height.

It has been proposed that a low bone density common in many elderly people is not sufficient for hip fracture to occur, but that the subject must also have sustained a fall for a fracture to occur. Multiple medical disorders, such as cardiac arrhythmias, cerebrovascular disease, medication side effects, as well as environmental hazards such as loose rugs, may be responsible for more falls among the elderly. There is overlap between Type I and II and persons with vertebral fractures are also more likely to have hip fractures.

Differential Diagnosis

Although postmenopausal and senile osteoporosis account for the majority of vertebral and hip fractures, they are not the only causes of osteoporosis. Other possibilities listed on Table I should also be considered.

TABLE I Causes of Ostepenia
Primary Hyperparathyroidism
Cushing's Syndrome
Tumors
Immobilization
Osteomalacia
Hyperthyroidism (Including iatrogenic)
Hypogonadism
Osteogenesis Imperfecta
Paget's Disease

Primary hyperparathyroidism occurs more commonly in women than in men, and may present as diffuse osteoporosis. Iatrogenic or endogenous hyperthyroidism is associated with increased bone turnover and bone mineral loss. Glucocorticoid-induced bone loss is more marked in trabecular than cortical bone. Of concern, are several reports that bone loss continues to occur in subjects taking alternate day steroids (3). Hypogonadism in either sex may result in osteoporosis. Myeloma cells may produce Interleukin I, a substance which has local bone resorbing effects. Patients with osteogenesis imperfecta may have many fractures in childhood but following puberty the disorder may be relatively quiescent, only to recur in the menopausal patient. Immobilization by a cast, splint or denervation will result in increased calcium mobilization. The same is true of bedrest which is extreme inactivity. Paget's disease of bone usually causes a characteristic radiographic picture. A rare form is diffuse however. Osteomalacia will have a different pattern on bone biopsy with an increase in bone matrix which is not calcified. Serum levels of calcium and phosphorus are low in osteomalacia, but not in osteoporosis.

Diagnosis

If an acute compression fracture occurs, there may be no changes on plain X-rays up to 3-4 weeks after the event. Eventually changes are evident, but may missed if measurements are not made. The ratio of the anterior and posterior height of the vertebrae body is normally .85-1.4 depending on the location. A ratio less than this constitutes a wedge fracture with more compression being designated grade 2. Severity of disease can then be classified by the number of fractures (2). Fracture rate is determined in this way; patients may have had no worsening of their symptoms.

Plain X-rays, however, are not especially useful in detecting early osteoporosis because at least 30 percent of the bone mineral density must be lost before a change is apparent. Furthermore, small changes occurring over a short period with or without therapy might not be appreciated. These problems led to the development of more sensitive techniques for the measurement of bone mineral density (4).

Two types of photon absorptiometry are available — single and dual photon. Both depend on the principle that the absorption of X-rays is dependent on tissue density. In other words, the more dense bone is, the fewer X-rays will be detected and counted on the side opposite the bone.

Single photon densitometry usually uses either 125I or 241AM. This is quick and reproducible and takes about 10 minutes, exposing the subject to a small amount of radiation (3 mrem). The radius is usually measured at the distal ⅓ (primarily cortical bone) and an ultradistal site (30 percent -70 percent trabecular bone). Measurement at the wrist does not allow accurate estimation of the spine mineral density. This method may have some utility in Type II osteoporosis where cortical and trabecular bone are both lost, but it cannot be used for spine measurement.

Dual photon absorptiometry (DPA) takes 20-40 minutes to do, exposes the patient to about 12 mrem and uses 153 gadolinium. Although there is a poor relationship between measurements by DPA, and actual bone mineral density, the method allows prediction of future fractures. It cannot be used if there is calcification in the aorta or if the vertebrae are deformed.

Quantitative CT (QCT) takes 10-20 minutes to perform but exposure is 100-500 mrem. It allows separate measurement of trabecular bone and allows prediction for future fractures.

Dual energy X-ray absorptiometry is the newest method. It uses 2 energies of X-ray for study and takes only 5 minutes to do, but requires special equipment. Studies of its ability to predict fractures are being done, but physicians have found it to be less useful than QCT (5).

Actual measurements of bone turnover can be done in several ways. Bone biopsies after tetracycline labeling measure new bone formation at the site of biopsy. This has the obvious disadvantages of being invasive and giving information only at a single area, usually trabecular bone at the iliac crest. Bone biopsy may, however, detect the 5 percent of osteoporotic patients who actually have osteomalacia.

Biochemical markers are also useful, osteocalcin or bone gla protein and bone specific alkaline phosphatase measure bone formation. Osteocalcin is a protein made by osteoblasts found only in bone and teeth. Some of it escapes into the serum and is excreted in the urine. It has been used to separate osteoporotic subjects into high, low and normal bone turnover groups. Bone specific alkaline phosphatase levels have been used similarly. Urinary hydroxyproline measures collagen degradation. About 50 percent of collagen turnover is in bone so measurements of hydroxyproline estimate bone turnover.

Since 99 percent of the body's calcium is in bone, a positive or negative calcium balance means gain or loss of bone. Balance studies require a metabolic ward where all intake and excretion can be measured over a defined short period of time and are expensive in time and resources.

The diagnosis of osteoporosis may be made using one or more of these modalities, if the problems of each are recognized.

Etiology

Osteoporosis has been variously proposed to be either a normal component of aging or a pathologic state. If it is a normal aging process, peak bone mass is important

because the fracture threshold will be reached sooner with the same rate of bone loss in a small-boned woman compared to a man with a large frame. Although lengthwise bone growth stops when epiphyses fuse, bone mass continues to increase until about age 25. During this time, from age 19-25, up to 5 percent-10 percent of the entire bone mass may be deposited as the cortical porosity decreases (6). This peak bone mass is primarily related to body size which is genetically determined. Although there is a relationship between bone density in daughters and mothers with osteoporotic fractures, a Swedish study found no increased frequency of fractures in the daughters compared to normals (7). Other important factors which may modify this peak mass are calcium intake and activity level during the time of bone mineral deposition. Lifelong calcium intake has been positively related to bone mineral density (8). This has raised concerns for the future. Calcium intake assessed at various ages in children is below that required to maintain a positive balance (9). This may presage an increase in osteoporosis as these children age.

Other studies have examined the effect of exercise on bone mass. Athletes in general have higher bone mineral density than control groups. This is true of both men, as well as women with normal menstrual cycles (10). The bone density is related to areas of stress. For example, the dominant arm in lifelong tennis players has a higher mineral content than the non-dominant arm which is similar to non-athlete controls.

Exercise also appears to retard the age related bone loss and may increase bone mass. However, if a woman becomes oligomenorrheic or amenorrheic from exercise, the effect of estrogen loss is not prevented, and bone loss is substantial. Although active women with amenorrhea have higher bone densities than sedentary amenorrheic women, both are far lower than normally menstruating sedentary women (11). The effect of exercise is clearly no substitute for estrogen.

Hormone Involvement

Due to the fact that hormones are involved in bone metabolism, many investigations have examined them. The response of parathyroid hormone to a hypocalcemic stimulus was less in an osteoporotic group than age-matched women with normal bone density (12). In the osteoporotic women, Vitamin D3 decreased significantly during hypocalcemia compared to either the control women or the young women. This study suggested that a greater PTH stimulus is necessary in older women to maintain Vitamin D levels.

Osteoporotics were noted to have a decreased amplitude and frequency of pulsatile PTH secretion compared to normal men (13). This may be of clinical relevance if normal pulsatile release of PTH is necessary for normal osteoblastic activity. Others have suggested that the elderly are less able to synthesize pro-Vitamin D in their skin (14).

Calcitonin inhibits bone resorption so its metabolism is of interest in osteoporotics. A recent study (15) suggested that osteoporotic women may have a specific reduction in ability to secrete calcitonin, resulting in lower basal levels.

Estrogen deficiency plays a major role in Type I osteoporosis and decreased ovarian function results in a universal bone loss. The bone loss increases from 0.5 percent a year to 2 percent-5 percent a year in the 8-10 years peri and postmenopausal. After this period, the rate of bone loss decreases to premenopausal rates. Estrogen deficiency results in increased bone turnover and rapid trabecular bone loss.

Circulating monocyte-macrophage cells from postmenopausal women produced increased levels of Interleukin I which has local bone resorbing properties (16). This was reversed with estrogen therapy. An estrogen receptor on bone cells has been implicated.

Estrogen also influences dietary calcium absorption with much less absorption in estrogen deficient states. The requirement is about 800 mg. of calcium/day in the subject who is replaced, but 1,000-1,500 mg per day in the estrogen deficient women. Estrogen, androgen and cortisol levels are, however, not different in those who are osteoporotic compared to non-osteoporotic subjects.

Prevention

Since therapy may be costly and less than optimum, it would be best to prevent the disorder. Two important aspects are: to ensure an adequate, but not excessive, level of exercise to increase peak bone mass and to increase calcium intake in young people. Dairy products are the major sources of calcium and their consumption in the low fat variety should be encouraged.

Estrogen therapy is recommended in peri and recently postmenopausal women who have no contraindiction for its use. Cessation of smoking and decreased alcohol consumption are also important. These measures are generally safe, effective and low in cost.

Therapies

Fluoride has been known to increase bone mass for over 100 years. However, in areas of high fluoride content in water, there actually are more fractures which suggests that despite increased bone density (fluorosis) the bone is less structurally sound.

The Mayo Clinic has been evaluating fluoride use in osteoporosis for many years. A recent study of 135 women with postmenopausal osteoporosis evaluated 4 years of treatment with fluoride (75 mg/day) compared to placebo (17). Bone density was increased in the spine in the fluoride group, but was not associated with a decrease in fracture rate. Unfortunately, the fluoride group sustained more complete and incomplete fractures in areas of primarily cortical bone, especially in the lower extremities. There was also a high incidence of side effects. This study has suggested that fluoride treatment results in less structurally sound bone. Its place in treatment of osteoporosis requires further study.

Vitamin D (Rocaltrol®) has also been used to treat osteoporosis. This therapy may be associated with hypercalcemia and increased urinary calcium excretion resulting in impaired renal function if not carefully monitored. Several studies,

but not all have, however, noted increased spine bone mass with fewer fractures (18,19).

Androgens have been noted to increase bone mass in hypogonadal men. Whether the effect is directly on the bone or indirect by increasing muscle mass is not known. The effect of nandrolone, an anabolic steroid, on vertebral density was studied in post-menopausal women, and compared to calcium, calcitrol and estrogen therapy (20). The dose was 50 mg IM every 3-4 weeks. Bone mineral density increased in the women receiving the androgen compared to bone loss in the spine of the other groups. Side effects of voice change or a mild increase in facial hair was noted in 30 percent of the subjects. However, androgens have also been shown to decrease HDL cholesterol, which may result in increased atherosclerotic heart disease.

Coherence or sequential therapy is an attempt to increase bone remodeling by stimulating bone metabolic units. The cycle of osteoclastic breakdown followed by osteoblastic synthesis of bone is about 3 months in young people and may be much longer in osteoporotics. This has also been termed ADFR for Activation, Depression, Treatment-Free and Repeat. Sequential therapy using subcutaneous PTH (1-38) and intermittent calcitonin given by nasal spray was used in a study by Jones (21). After 14 months of therapy, increased vertebral density was not accompanied by changes in cortical bone as measured in the forearm. The mechanism postulated was stimulation of osteoblasts with PTH and inhibition of osteoclasts by calcitonin. There was a wide range of responses and more study is needed.

Several studies have used diphosphonate to suppress osteoclasts (22,23). Phosphate has been used to stimulate osteoblasts, probably by its effect to increase PTH. Cyclical etidronate (400 mg) was given for 2 weeks either with or without phosphorus in a cycle of 91 to 105 days. Subjects were followed for up to three years. Bone mineral density in the spine increased significantly (up to 5 percent) from baseline in the etidionate groups. The addition of phosphate did not appear to make any difference in response. Bone density was not changed or slightly increased in the hip with etidronate alone.

Calcium supplementation may be important in those postmenopausal women who have a low calcium diet. Jones (24) gave supplemental calcium to two groups of 68-year-old women, those taking <400 mg. calcium/day compared to 800 mg./day and compared them to placebo groups. In the low calcium group, there was more bone lost from the spine, femoral neck and radius than in the high calcium group. Calcium citrate appeared to be more effective than calcium carbonate. Additional calcium appeared to have little effect in the group with a higher calcium intake. It should be noted however that calcium did not increase bone mineral density, but only maintained it.

An interesting model for osteoporosis has been produced in the turkey. If the bone in the wing which is comparable to the ulna is denervated but otherwise left intact, it becomes osteoporotic. If an electromagnetic stimulus is given by a pulse delivered by a device that the turkey wears on the wing, new bone is formed and osteoporosis is prevented (25). This form of therapy may be useful in the future.

A modest amount of weight-bearing exercise has been shown by several authors to increase bone mass (26). This may also have significant cardiovascular benefits.

The therapy of osteoporosis should be tailored to the individual by eliminating exacerbating factors or medications if possible, ensuring adequate calcium intake and appropriate weight-bearing exercise, and considering the use of cyclical etidronate.

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1. Ann Intern Med 1982;96:766-71.

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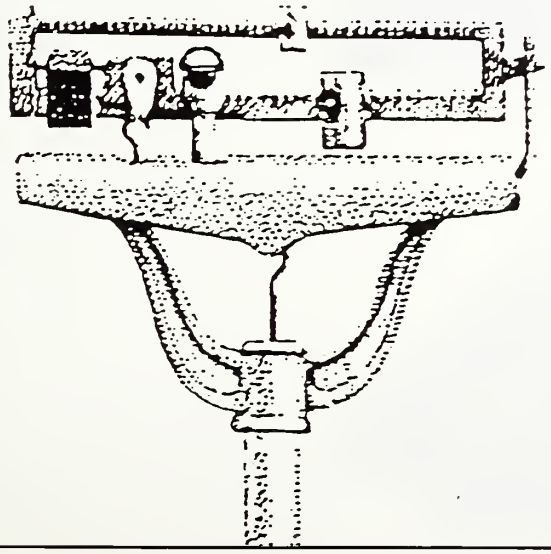

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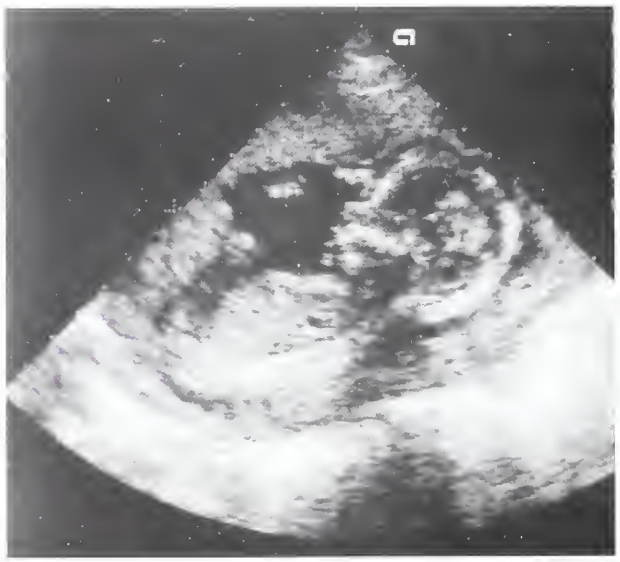

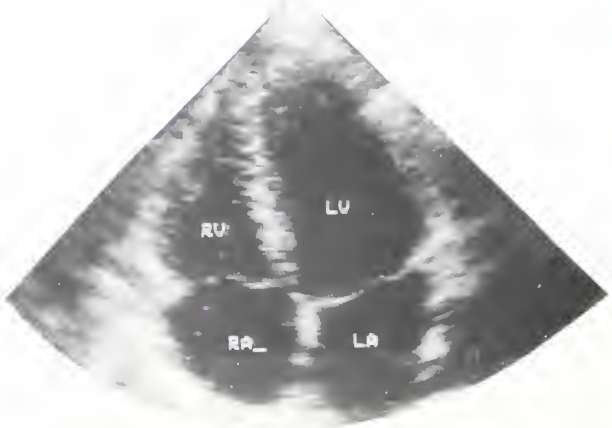

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President's Page

Michael M. Stump, M.D.

The Love of Family

At a time when I have reached an age often reserved for philosophic contemplation and retrospective review of the essential elements that have made up one's life, I should like to ask your indulgence as I make a few private observations in my last President's Page.

I have realized over my lifetime that the three great imperatives of life are the love of God, the love of the family, and the love of country. A fourth essential in my life has been the love of medicine.

It is the great imperative of family that I would like to address from a philosophical as well as a personal viewpoint.

Philosophically speaking, most dictionaries define family as the basic unit of society having at its nucleus two or more adults living together and cooperating in the care and raising of their offspring.

It is from this fundamental family structure that cultures have sprung and upon which civilizations have been built. It is from this family unit that society has evolved its various morals, habits and manners, laws and institutions.

For us of Old or New Testament persuasions, God created the first family in Adam and Eve. Joyfully and lovingly, they were created for each other and for himself. They were told to be fruitful and multiply. God dealt with them in a firm and loving manner and taught them the differences between good and evil.

These Judeo-Christian ideals of God and family combined with concepts inherited from the Greek and Roman empires gave western civilization its foundations in religion, ethics, law and government. From these beginnings, our ideals of equality, fairness and opportunity ultimately sprang. It was by the application of these concepts of individuals and families living equally, independently and cooperatively under law in the pursuit of happiness that our great American experiment was born.

America is a fortunate and gifted child having sprung from notable parents, but America will have to struggle to pass on its great family inheritance to those children who shall follow.

Personally speaking, my view of one's own family is encompassed by one word — LOVE. The love and respect and cherishing of the husband for his wife and the love and respect and cherishing of the wife for her husband, is the dynamic that starts the family formation as a meaningful vigorous partnership.

Into this great shelter of love and respect our children are born or adopted. Joy and thanksgiving abound with each new arrival along with our natural apprehension and appreciation of new responsibility. Both of us as partners pray to be good parents and rear our children according to those things that we believe right.

Sadly, in our own personal world we don't always adequately nurture the love we have for each other or that we have for our children. We accept it and know it is there, but we often push it aside because we are too frantically busy. In doing this, we miss the very essence of a truly satisfying family life.

Part of that essence is sharing the simple joy of tending the garden we have planted and formed together — walking in it, enjoying it and helping it to grow. This involves being a part of the family picnic, laughing at the antics of new kittens, admiring a new tricycle or bicycle, going to a ball game or just sitting down to a leisurely family dinner to enjoy and share relaxed or stimulating conversation.

To watch little children grow is a wonderful experience. We share with them the things we believe to be good and true as we watch them stumble and fall and get up and go again. We watch them grow and develop and try their wings as they fly just a little distance from the nest and back. Eventually those wings will carry them long distances, but in their hearts will be the love and traditions they learned as a child. These ideals and impressions will become a rich part of the tapestry of the life of a future family yet to be formed.

On behalf of my wife and myself, I ask your permission to express this parting belief.

After God, your family should be your unrivaled priority as you exercise the wonderful gift of love. It is because of family you can be and do. Here you will discover and truly understand the real meaning of life. Here you will find the poetry that endures.

Please do not tragically neglect the love of family.

Michael M. Stump, M.D.

Michael M. Stump, M.D.

Few who have not had the personal experience of the office can appreciate the grueling nature of a year spent as president of the West Virginia State Medical Association. There was some concern last year, when a month or two before he was to take office, Mike Stump experienced a few cardiac irregularities.

It was our good fortune that this passed, and Mike spent a vigorous year leading the WVSMA through a maze of legislative and regulatory trials occasioned by maneuverings of political leaders and their functionaries. At this task and as the WVSMA spokesman, Dr. Stump performed, as he has in the past, with extraordinary capability.

In a related vein, anyone who has read his monthly comments in the *Journal* must recognize that this is one of the most articulate and best informed physicians West Virginia has seen in many years. Dr. Stump is well read, always well prepared with all the facts and references, and he has the mind to put it all together in lucid form.

One of the most notable services he has performed for all West Virginians is the preparation and personal lobbying for the West Virginia AIDS bill passed by the Legislature in 1988. Although the law as passed failed to require routine AIDS testing on all hospital admissions, a position advocated still by the WVSMA, the West Virginia law on this subject is still regarded nationally as one of the most enlightened in the country today.

A matter about which one must search diligently for information from others is the military service record of Dr. Stump. During the Korean War, he was awarded the Soldiers Medal for heroism for his exploits in saving innumerable lives at great risk to himself following a train wreck in Korea.

In addition to his other leadership responsibilities, Dr. Stump took it upon himself to analyze Association office policies and procedures and to effect certain salutary changes. The past year has seen a new efficiency and a new economy in the management of Association affairs which will benefit the WVSMA in all of its activities for many years to come.

None of this is a surprise to anyone familiar in any way with the length of his curriculum vitae and the breadth of his activities in research, practice and organizational activities in local, state, and national specialty and federation groups and societies of every variety. It seems he was fated to be a leader in whatever group he joined.

Dr. Stump, throughout the past year, has repeatedly demonstrated for members of this Association the multiple facets of his personality and his enormous talents. We are grateful for his dedicated service.

The WVSMA is a stronger and better organization as a result of his untiring efforts as our president.

—SDW

Special Correspondence

JOHN D. ROCKEFELLER IV
WEST VIRGINIA

United States Senate

WASHINGTON, DC 20510-4802

July 1, 1991

Dear Friends,

I am writing you to let you know that I am deeply disappointed and concerned about the new, resource-based fee schedule for physician services recently proposed by the Health Care Financing Administration (HCFA). As you know, this Medicare fee schedule will be phased-in over 5 years beginning next year. I want you to know that I am working diligently on this issue and making every attempt to develop a strategy for achieving the goals we set together when physician payment reform legislation was enacted in 1989.

First, let me say that this issue is very complex. Some of the problems with the proposed fee schedule are indeed related to technical problems with the phase-in period. However, other problems, including certain assumptions made by HCFA, are not. Dr. Wilensky, HCFA's Administrator, announced this week that Medicare reimbursement for physician services would be reduced by almost $15 billion over 5 years under HCFA's proposed resource-based fee schedule. This is totally unacceptable.

I have become increasingly convinced that HCFA has deliberately circumvented Congressional intent in their design of the new, resource-based fee schedule. In order to hear from all sides, I have scheduled a hearing in my subcommittee on Medicare for Friday, July 19, 1991. In the meantime, I have sent a letter to Secretary Sullivan, along with Senator Bentsen, Chairman of the Finance Committee, and my other colleagues on the Finance Committee, requesting a clear accounting of the events that took place at HCFA during its development of the resource-based fee schedule. I am interested in knowing when HCFA first realized that there was a problem, inparticular, when they realized the magnitude of the problem.

Two years ago, when I introduced physician payment reform legislation with my colleague Senator Durenberger, our legislation required implementation of the new, resource-based fee schedule on a budget-neutral basis over 5 years. Unfortunately, during House-Senate conference negotiations, this budget neutrality provision was dropped at the request of the Administration and, at that time, the American Medical Association opposed a 5-year budget neutrality provision. In hindsight, a 5-year budget neutrality provision would have prevented HCFA from manipulating the resource-based fee schedule to make deep cuts in physician payments under Medicare.

I am committed to the development of a rational and equitable fee schedule based on resource costs. What HCFA has proposed to date is clearly not reflective of Congressional intent.

It is important to me to stay in touch with West Virginia physicians, not only on physician payment reform, but on the broader issue of overall health care reform. I have the utmost respect for the work you do. Your advice and counsel have been incredibly helpful to me since I came to the Senate, and especially important since I assumed chairmanship of the Medicare subcommittee more than two years ago. Please know that I plan to do everything possible to achieve our mutual goal of fair Medicare reimbursement for physician services.

My best wishes.

Sincerely,

John D. Rockefeller IV

Editor's Note: *Physicians are encouraged to contact Senator Rockefeller to thank him for leadership and support of a fair Medicare reimbursement for physician services. His address is The Honorable John D. Rockefeller IV, 724 Hart Senate Office Building, Washington, D.C. 20510, (202) 224-6472.*

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Dr. Amores to be Installed as WVSMA President

Constantino Y. Amores, M.D., will take the WVSMA presidential oath of office on Saturday, August 17, during the Second Session of the House of Delegates at the WVSMA's 124th Annual Meeting at The Greenbrier.

A native of the Philippines, Dr. Amores received his doctor of medicine degree in 1961 from the University of Santo Tomas in Manila. After graduation, Dr. Amores did a one-year rotation in a public charity hospital and then began practicing general family medicine in his hometown on Mactan Island.

Dr. Amores decided to come to the United States in 1963 for an internship at Memorial Hospital in Phoenix. The following year, he stayed in Phoenix to do a pathology residency at St. Joseph's Hospital and then in 1965 moved to New York for a two-year surgery residency at Nassau Hospital in Mineola. To complete his postgraduate studies, Dr. Amores relocated to Pittsburgh, where he studied neurosurgery at Mercy Hospital and Children's Hospital and then taught basic neural sciences at the University of Pittsburgh.

In 1971, Dr. Amores and his wife, Diana, a radiologist, selected Charleston as their new home after considering offers from many other states and the Philippines. They chose Charleston because they were so impressed with the friendliness of the people and thought it would be an excellent place to raise their four children and pursue their careers. Dr. Amores opened his neurosurgery practice that year and joined the staff of Charleston Area Medical Center, St. Francis Hospital, Thomas Memorial Hospital and the former Kanawha Valley Hospital.

After 14 years in the Charleston medical community, in 1985 Dr. Amores was elected chief of staff at CAMC and was also elected to the

Dr. Constantino Y. Amores

Executive Council of the Kanawha Medical Society. The following year, he became president of the Kanawha Medical Society and was voted in as a member of the WVSMA Council. In addition, from 1987-90, Dr. Amores served on the CAMC board of trustees.

A diplomate of the American Board of Neurological Surgery, Dr. Amores is also a member of the American Association of Neurological Surgeons, the Congress of Neurological Surgeons of America, the Australian-Asian Neurological Society, the International College of Surgeons and the Society of Philippine Surgeons of America.

The Amores have a special interest in music and Dr. Amores is a founding member of the Board of Governors of the Charleston Conservatory of Music and Fine Arts, and Diane serves on the board of trustees of the West Virginia Symphony. In addition, Dr. Amores is the founding president of the Philippine Community Association of West Virginia, which strives to keep the country's heritage and culture alive among the Filipinos now living in West Virginia, and for the past five years he has served on medical missions to his homeland.

In his list of priorities as president of the WVSMA, Dr. Amores plans to focus much of his attention on helping put the "country-doctor bedside manner" back into medicine.

"I feel it is vital that doctors take the time to actually care for their patients and not just treat them," Dr. Amores said. "Technology has greatly advanced medicine but it has also impersonalized it as well. Patients need to know that they are our number one concern at all times," he added.

AMA To Conduct Media Workshop at Convention

Physicians who want to enhance their communications skills so they can speak more effectively to reporters may sign-up for the "Meet the Media" presentation which will be held on Thursday, August 15, during the WVSMA Annual Meeting at The Greenbrier.

Pat Clark, AMA director of media relations, will conduct the 90-minute session which features some role playing and interaction from the participants. This workshop begins at 1:30 p.m. in the Taft Room and is limited to the first 50 people who enroll at the WVSMA Registration desk.

A registration form for this year's Annual Meeting can be found on page 365 and following it is a special section which lists the schedules for both the WVSMA's and the Auxiliary's meetings; names of delegates and alternates; and the names of the exhibitors and their representatives.

For more information about any of the Annual Meeting events, contact Nancie Divvens at 925-0342.

AMA, SMA Auxiliary Leaders To Head Annual Program

Mrs. Sherry Strebel

Mrs. Roberta Barnett

Mrs. Sara Townsend

Mrs. Janie Altmeyer

Sherry Strebel, president of the American Medical Association Auxiliary, and Roberta Barnett, president of the Southern Medical Association, are the featured speakers for the WVSMA Auxiliary's 67th Annual Meeting at The Greenbrier on August 14-17.

Mrs. Strebel will deliver the keynote address to the auxilians Thursday, August 15, during the First Session of the House of Delegates, and Mrs. Barnett's presentation will be made on Friday, as part of the events for the Second General Session.

Sara Townsend, president of the WVSMAA, will preside over the business meetings at the convention and will install Janie Altmeyer as the new president during the Second General Session of the House of Delegates.

Speakers Profiled

Mrs. Strebel of Oklahoma City, Okla., was installed as president of the AMAA in June after serving the organization as president-elect, secretary, Southern Region vice president, director, and member of the Finance and Long-Range Planning Committees. In addition, during her years of involvement with the AMAA, Mrs. Strebel has been chairman of the Legislation Committee and auxiliary representative to the AMA Council on Legislation.

Her interest in politics led Mrs. Strebel to participate in the American Medical Political Action Committee (AMPAC) campaign manager's school and subsequently to a position as campaign coordinator for Oklahoma gubernatorial candidate Bill Price. She currently is a member of the Oklahoma State Medical Association Council on State Legislation and the Oklahoma Medical Political Action Committee.

A graduate of the University of Oklahoma, Mrs. Strebel holds a bachelor's degree in business education. She and her husband, Gary, an obstetrician/gynecologist, have three daughters.

Mrs. Barnett and her husband, Jim, have the distinction of being the first husband and wife selected to lead the SMA and its Auxiliary at the same time. They were both installed at the SMA's Annual Scientific Assembly in Nashville in October.

A graduate of Colorado Woman's College, Mrs. Barnett has been active in the Mississippi State Medical Association Auxiliary for 26 years. She recently helped to create a booklet along with MSMA's legal counsel entitled "What Every Physician's Spouse Should Know About Professional Liability."

Mrs. Barnett has been involved with SMAA since 1980. She and her husband both love flying and so they chose the theme of "On the Leading Edge" for both the SMA and its Auxiliary this year.

The Barnetts reside in Brookhaven, Miss., where Mrs. Barnett is the office manager for Dr. Barnett's practice.

Officers Highlighted

Mrs. Altmeyer, the incoming WVSMAA president, has been active in auxiliary activities since her husband, Rob, opened his pulmonary medicine practice in Wheeling in 1981.

Before she was elected president, Janie had served the WVSMAA as Northern Region director and president-elect. In addition, Janie was president of the Ohio County Medical Society in 1987 and currently serves as treasurer.

A secondary education graduate of West Virginia University, Mrs. Altmeyer taught junior high math before assuming her role as office manager for her husband's practice. The Altmeyers have two sons and Mrs. Altmeyer serves on the board of the Easter Seal Rehabilitation Center.

Mrs. Townsend, had been chairman of the Bylaws and Handbook Committee, chairman of the Special Pin Project, Eastern Region director, vice president and president-elect before assuming her current position as president.

Born in Halifax, N.C., Mrs. Townsend holds a bachelor's degree in nursing from the Medical College of Virginia. She is past president of the Eastern Panhandle Medical Society Auxiliary and is a member of the Organization Study Committee of the National Council of State Garden Clubs, Inc.

Mrs. Townsend's husband, Vince, is an internal medicine specialist in Martinsburg and the couple has three sons.

Kellogg Foundation Awards $6 Million to State Medical Schools

West Virginia's medical education system has received a $6 million grant from the Kellogg Foundation.

Governor Gaston Caperton announced the grant on June 20 during visits to the three medical campuses and said he will ask the Legislature for an additional $6 million to supplement the grant.

The product of a year-long collaborative effort by Marshall University, West Virginia University and the West Virginia School of Osteopathic Medicine. The far-reaching proposal will redirect state medical education towards a more rural, community-based and multi-disciplinary model. Professor Bill Carlton of the Department of Community Medicine at WVU coordinated the grant application on behalf of all three medical schools.

The schools will develop rural training sites in medically underserved areas where faculty and students representing seven professional schools and four health disciplines (medicine, nursing, dentistry, and pharmacy) will interact.

Under the Kellogg grant, existing primary care centers in Spencer, Rainelle and Camden-on-Gauley will be transformed into academic centers for education, research and service during the first year of the project. The matching plan proposed by Caperton would allow the development of six additional centers.

"Our goal is to change the focus of medical education toward ambulatory, outpatient, preventive care and away from hospital-based, high-technology, end-stage treatment," said Dr. Linda M. Savory, assistant dean for curriculum development and evaluation at MU who participated in proposal development with representatives from the other schools.

At the rural sites, teams of student doctors, nurses, dentists and pharmacists will gain skills needed to resolve the multiple health and social problems of specially identified family units. The students will also learn how to design applied research projects at their community's specific health needs.

Kellogg's criteria for funding emphasizes integrating health care, teaching and research in a community setting, having significant community participation, meeting the needs of the community's underserved, and collaborating with a variety of health professions schools.

All medical and nursing students will rotate through the revised curriculum, with some students spending six months or longer working and learning in the rural centers. Field professors from each discipline will guide educational activities at the centers and also serve as part-time practitioners.

WVSMA ANNUAL MEETING TOURNAMENTS

Golf

Thursday, August 15
noon

Estelito Santos, MD, Chairman

Trophies by Marion Labs

Volleyball

Thursday, August 15
2 p.m.

James Comerci, MD, Chairman

Prizes by WVSMA

Tennis

Thursday, August 15
2 p.m.

William Scaring, MD, Chairman

Trophies by A.H. Robbins

Sign up for tournaments at the WVSMA Registration Desk at The Greenbrier

Symposium to Provide Day Care Info for Pediatricians

The first national comprehensive "Symposium on Day Care for Children," will be held in Washington, D.C., October 4-5, and is slated to attract pediatricians, government officials, and leading child care authorities.

Organized by The Institute for Pediatric Service of Johnson and Johnson Consumer Products, Inc. and co-sponsored by the American Academy of Pediatrics, the symposium is designed to provide pediatricians and other professional child care givers with information which will assist them in helping parents make informed day care decisions. Another emphasis of the conference will be to encourage pediatricians to recognize the important potential contribution they can make in the development of day care programs in their communities.

Featured speakers for the meeting include Ruth T. Gross, national study director of the Infant Health and Development Program at Stanford University; Congresswoman Pat Schroeder; nationally-known pediatrician T. Berry Brazelton; and Edward Ziegler, Ph.D., director of the Bush Center in Child Development and Social Policy at Yale University.

Registration fee for the symposium is $250 for physicians; $150 for nurses, allied health professionals, educators and day care professionals; and $100 for residents, graduate students and others in training.

To register, enclose a check made payable to Johnson & Johnson Consumer Products, Inc., and mail, with name, telephone number, address and professional specialty to Audrey K. Brown, Chairman, Board of Trustees, Institute for Pediatric Service of Johnson & Johnson Consumer Products, Inc., Grandview Road, Skillman, NJ 08558.

Special reduced hotel rates are available by calling The Ritz-Carlton, Pentagon City, at 1-800-241-3333 or (703) 415-5000. In addition, special rates have been arranged with United Airlines for symposium registrants. For details, contact the American Academy of Pediatrics Travel Office at 1-800-433-9016.

ASAM Program Studies Adolescent Nicotine Addiction

The effect of nicotine on adolescents and how increased awareness and implementation of policies can have an impact on preventing tobacco use, is the focus of the Fourth National Conference on Nicotine Dependence, September 13-15, in Raleigh, N.C.

Sponsored by the American Society of Addiction Medicine, the meeting will feature topics of importance in the area of adolescent tobacco use such as targeted advertising, the effect of tobacco-free policies in schools, chemical use patterns in adolescents, children's access to tobacco products, and the use of smokeless tobacco. Other subjects range from passive smoking and the psychological aspects of smoking to providing smoking cessation services to the elderly and to patients with other chemical dependencies.

Registration material can be obtained by writing or calling ASAM, Suite 409, 5225 Wisconsin Avenue, N.W., Washington, D.C. 20015, (202) 244-8948.

Wise to Speak at Office Managers Annual Conference

The Office Managers Association of Health Care Providers will hold its fifth annual conference entitled "RX for Health Care Changes" at Silver Creek Resort on September 19-21.

Special guest speaker for the meeting is Congressman Bob Wise who will discuss "Health Care in the 90s."

In addition to the educational and social events planned for the conference, vendors from various medical, office supply/equipment companies and pharmaceutical representatives will have booths to display their products from 6 p.m. - 9 p.m. on Friday, September 20.

For more information about the meeting or forming an office manager section in your area, contact Wanda Fisher at 347-9225 or Teresa Painter at 345-5421.

Multiple Sclerosis Topic of OSU Meeting

The latest information regarding multiple sclerosis will be presented at "The Fourth Annual Multiple Sclerosis Update-1991" on September 13, sponsored by The Ohio State University Hospitals' Center for Continuing Medical Education.

Advances in the treatment of MS will be presented by Dr. John N. Whitaker, professor and chairman of the Department of Neurology at the University of Alabama in Birmingham. His research has focused on proteins in the nervous system found in myelin, specifically, myelin basic protein. Several Ohio State faculty members will also be participating in the conference.

The program meets the criteria for 6.75 hours in Category I of the Physician's Recognition Award of the American Medical Association.

For more information, contact Ohio State's Center for Continuing Medical Education at 1-800-492-4445 or (614) 292-4985.

Seminar Focuses on Hearing Impaired

The 2nd Annual Conference for the Hearing Impaired is entitled "Hearing the Need···Answering the Call" and will be held at the West Virginia University Health Sciences Center in Morgantown on September 26-28.

Co-sponsored by West Virginia Hospital Research Education Foundation — Benedum Project for the Hearing Impaired and WVU, this seminar focuses on the needs of deaf and hearing impaired children and adults to establish dialogue and begin to create a statewide plan for improving the equality of life for the deaf. Workshops will be offered for physicians, audiologists, nurses, speech pathologists, social workers, teachers, parents and deaf and hearing impaired children and adults. CME credits are available for physicians and applied for nurses and social workers.

For additional details, call Sharon Spencer at 744-9842.

Continuing Education

Listed on this page are some of the upcoming continuing education programs which will be held throughout the state.

The programs this month were compiled by the following individuals: Patricia Barnhart, WVSMA loss control/CME accreditation coordinator; Robin Rector, coordinator of CME for Charleston Area Medical Center; Cynthia Kemp, WVU conference planner; David Bailey, MU director of CME; and Thelma Wilson, education coordinator of the Raleigh County Medical Society.

These programs are tentative and subject to change. Further details about these CME activities may be obtained by calling Barnhart at 925-0342; Rector at 348-9580; Kemp at 293-3937; Bailey at 696-7018; and Wilson at 255-6341. Other national and state meetings are listed in the Medical Meetings Section of the *Journal.*

This schedule is presented as a convenience for physicians. If you would like to have the continuing education programs offered by your institution or association published in the *Journal,* please contact Nancy Hill, managing editor, at 925-0342.

West Virginia State Medical Association - Charleston

August 14-17 - WVSMA's 124th Annual Meeting, The Greenbrier, White Sulphur Springs

CAMC/WVU Health Sciences Center - Charleston

August 8 - "Athletic Practice: Heat Illness Prevention" (Sports medicine teleconference), co-sponsored by WV Chapter of American Academy of Family Physicians, 3 p.m. - 4 p.m.

August 12 - "Aphasia Disorders" (Teleconference), 12:30 p.m. - 1:30 p.m.

August 26 - "Trauma Update: Initial Assessment and Transfer," (Teleconference), 12:30 p.m. - 1:30 p.m.

WVU Health Sciences Center - Morgantown

August 30-31 - "The Foreseen and Unforseen Risks of Cytokine Therapy"

September 6-7 - "Behavioral and Developmental Pediatrics"

MU School of Medicine - Huntington

August 19 - "Advances in Parkinson's Disease Treatment," Alumni Lounge, Student Center, 7 p.m.

September 4 - Update on Lipid Management, (Teleconference) noon

Raleigh County Medical Society-Beckley

August 7 - "Hospital Acquired Pneumonia," John W. Hoyt, M.D., Raleigh General Hospital, 8 a.m.

August 7 - "Aspiration Pneumonitis," John W. Hoyt, M.D., VA Medical Center, noon

August 20 - "Advances in Hepatology," Allan Glombicki, M.D., VA Medical Center, noon

Outreach Programs

Key to Sponsors

★ WVU Health Sciences Center, Morgantown

☐ CAMC/WVU Health Sciences Center-Charleston

(Check locally for more details)

Logan ☐ Logan General Hospital, August 16, 11:30 a.m., "Spinal Cord Injuries," Mario Balmeseda, M.D.

Man ☐ Man Appalachian Regional Hospital, August 20, 7 p.m., "Analysis of Patient Referrals," Ganpat Thakker, M.D.

Montgomery ☐ Montgomery General Hospital, August 7, noon, "Spinal Cord Injuries," Mario Balmeseda, M.D.

Ripley ☐ Jackson General Hospital, August 9, noon, "Head Trauma," Constantino Y. Amores, M.D.

Spencer ☐ Roane General Hospital, August 20, noon, "Spinal Cord Injuries," Mario Balmeseda, M.D.

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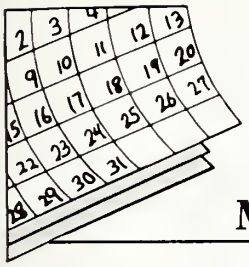


Medical Meetings

August

14-17—West Virginia State Medical Association's 124th Annual Meeting, White Sulphur Springs.
20-Sept. 1—Annual Meeting of the American Academy of Pain Management, Baltimore.
24-25—Automated Perimetry: Introduction and Clinical Correlation for Physicians and Technicians, Ohio State University, Columbus.

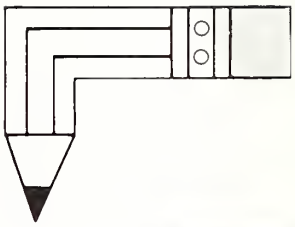
September

3-8—American Academy of Neurological and Orthopaedic Surgeons, Las Vegas.
5-7—American Gynecological and Obstetrical Society, Carlsbad, CA.
6-7—Prostate and Bladder Cancer, Ohio State University, Columbus.
11—Impairing Diseases in Our Colleagues, Families and Patients, Indiana State Medical Association Commission on Physician Assistance, Evansville, IN.
11-13—Administration in Human Service Organizations: The Transition from Clinician to Manager, The Menninger Clinic, Topeka.
12-17—College of American Pathologists, New Orleans.
13—Multiple Sclerosis, Ohio State University, Columbus.
13—Fourth Annual Multiple Sclerosis Update, Ohio State University, Columbus.
13-15—Fourth National Conference on Nicotine Dependence, American Society of Addiction Medicine, Raleigh, NC.
22-27—American Society of Maxillofacial Surgeons, Seattle.
22-27—Weeklong MRI Fellowship, Magnetic Resonance Imaging Education Foundation Inc., Cincinnati.
23-24—5th NIMH International Research Conference: The Classification, Recognition and Treatment of Mental Disorders in General Medical Settings, Washington, D.C.
24-27—American Group Practice Association, Honolulu.
26-28—American Academy of Facial Plastic and Reconstructive Surgery, Kansas City, MO.
26-28—2nd Annual Conference for the Hearing Impaired: Hearing the Need ··· Answering the Call, WV Hospital Research and Education Foundation and West Virginia University, Morgantown.
26-29—American Academy of Family Physicians, Washington, D.C.

For More Information . . .

Contact the Journal for additional information about most of the above meetings. Call (304) 925-0342.

Poetry Corner



Lemme be

A sign says National Seashore
stay off the grass.
Another says soft sand --
stay on the berm,
Park only on approved land
Leave only your tracks in the sand

No food, no drink
Thanks for not smoking
Drive this way
Drive that way
(Drive any way you damn please)

I'm beginning to get a little tired
of being told
What to eat and where to sit
or when to sneeze

Do you ever get the feeling
That the ring in your nose
is tightening
Let me live the pretense
that i'm free
The ones in control don't know it
Or they pretend not to show it
Heavens!! I'm free --
Only the Lord knows what
to do with me
SO LEMME BE

J. Paul Aliff, M.D.

Keeper

He hit the bait then took the hook
And broke the surface of the
stream.
Oh, what a sight he was
As sunlight glinted off his back!
Now he was off and swimming
hard
While the line played out
With singing of the reel.
But as I started reeling in the line,
My pole bent double with the
weight
And all the fight he had to give.
Then when I saw him once again
leap high,
A beauty of a trout, my heart was
fairly
Bursting in my chest as I played
him in
With hope the line would stand the
test.
And as I netted him at last
I saw he was indeed a keeper!

E. Leon Linger, M.D.

Please address your submissions for Poetry Corner to: Stephen D. Ward, M.D., Editor, West Virginia Medical Journal, Box 4106, Charleston, WV 25364.

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Join us in this dramatically different medical meeting and experience the vitality of two intriguing worlds. Simply complete the registration form below and return it to us. We'll see you there!

The West Virginia State Medical Association is

Bringing It All Together

West Virginia State Medical Association
124th Annual Meeting
August 14 - 17
The Greenbrier
White Sulphur Springs, WV

ADVANCE REGISTRATION FORM

Physician Members & Physician Assistants - $125.00 *Physician Non-Members - $175.00*
Students, Residents & Nurses - No Charge

Name _____

Address _____

Phone _____

Specialty _____

Make checks payable to WVSMA and mail completed form to P.O. Box 4106, Charleston, WV 25364
(304) 925-0342

WEST VIRGINIA STATE MEDICAL ASSOCIATION

124TH ANNUAL MEETING

AUGUST 14-17, 1991

THE GREENBRIER, WHITE SULPHUR SPRINGS, WV

PROGRAM

The WVSMA staff would like to recognize members of this year's Annual Meeting Program Committee and the effort put forth by each individual. The success of the meeting is due to the planning and organizing that takes place each year before the meeting begins. The time and initiative taken by these people is sincerely appreciated by the staff and all those who have the opportunity to participate in the Annual Meeting:

Stephen L. Sebert, M.D., **Chairman,** *Morgantown*
James L. Bryant, M.D., *Clarksburg*
Constantino Y. Amores, M.D., *Charleston*
Thomas H. Chang, M.D., *Clarksburg*
Richard C. Daniel, M.D., *Beckley*
Erlinda De La Pena, M.D., *Clarksburg*
David A. Denning, M.D., *Huntington*
Michael J. Lewis, M.D., *Morgantown*
Maurice A. Mufson, M.D., *Huntington*
Edward Pinney, M.D., *Martinsburg*
Mabel M. Stevenson, M.D., *Huntington*

PRE CONFERENCE MEETINGS

Tuesday Evening, August 13

6:00 Executive Committee meeting
Michael M. Stump, M.D., President, presiding
Pierce Room

7:30 Dinner, Fillmore Room

Wednesday August 14

8:30 Exhibit set-up

9:00 WVSMA Council Meeting
Derrick L. Latos, Chairman, presiding
McKinley Room

11:30 Council Luncheon, Chesapeake Bay

Wednesday Afternoon, August 14

12:00-4:30 Registration
Exhibit Center Foyer

12:30-1:30 Delegate Registration, Governor's Hall

1:00-4:30 Exhibit Visitation

1:30-5:00 WVSMA First Session House of Delegates
Governor's Hall

Call to Order and Welcome
Michael M. Stump, M.D., President

Invocation

Introductions: Visiting State Presidents
1991 Annual Meeting Program Committee
WVSMAA President
WV Hospital Association President

2:00 "AMA Positions on Health Care Issues Facing America Today"
John J. Ring, M.D., AMA President

2:30 BREAK

Call to Order—Michael M. Stump, M.D., President

WVSMA Rural Health Physician of the Year Award

Presentation of AMA-ERF Grants

WVSMA Presidential Citation

Wyeth-Ayerst Physician Award for Community Service

3:00 Presidential Address, Michael M. Stump, M.D.
"The President and the Office"

Business Meeting
Nominating Committee report and speeches
Introduction and open session of resolutions

5:00 Adjournment

Wednesday Evening

6:30-7:30 Presidential Reception, Taft Foyer
Courtesy SmithKline Beecham

Thursday, Morning, August 15

7:30 Specialty Sections/Society Legislative Representatives Informal Breakfast Meeting
F. Thomas Sporck, M.D., presiding
Main Dining Room

8:30-2:00 Registration, Exhibit Center Foyer

Exhibit Visitation, Exhibit Center

First General Session
Governor's Hall

9:00 Call to Order and Welcome
Michael M. Stump, M.D., President
Invocation
"Regulators' Recipe for Patient Care"
Stephen L. Sebert, M.D., Moderator

9:15 "Rules and Regulations, WV Board of Medicine: Who's Watching Who?"
Eileen Catterson, M.D., President, WV Board of Medicine

9:45 "The PRO Process"
Harry S. Weeks, M.D., Medical Director, West Virginia Medical Institute

10:15 "Environmental Health—The Infectious Medical Waste Act"
Joseph P. Schock, MPH, PE, Director, Office of Environmental Health Services of West Virginia

10:45 BREAK

11:15 Questions and Answers

12:00 Adjournment

Thursday Afternoon, August 15

12:00 Young Physicians Section Luncheon Meeting
David W. Avery, M.D., presiding, Grant Room
George E. McGee, M.D., AMA, Hattiesburg, M.D.

12:00 Component and Specialty Society Presidents Luncheon
Michael M.Stump, M.D., President
Derrick L. Latos, M.D., Council Chairman
Co-hosts, Chesapeake Bay

1:30-3:00 "Meet the Media"
Pat Clark, Director of AMA Media Relations
Taft Room

Thursday Afternoon, August 15

1:30 Committee on Resolutions
Constantino Y. Amores, M.D., presiding
Hayes Room

2:00 Golf, Tennis, Volleyball Tournaments

3:00-5:00 WESPAC Meeting
Ester Weeks, Chairman, presiding
Fillmore Room

Thursday Evening

6:30-7:30 Reception
Courtesy, CNA Insurance Companies and McDonough Caperton Insurance Group
Colonial Terrace

7:30-10:00 Hospitality Room, Courtesy P.I.E. Mutual Insurance Co., McKinley Room

Friday Morning, August 16

7:00-8:30 WVSMA Section on Surgery Breakfast Meeting
Chesapeake Bay
"Current Management of Inflammatory Bowel Disease"
Victor W. Fazio, M.D., F.A.C.S., Chairman, Department of Colorectal Surgery, The Cleveland Clinic Foundation

7:30 WV Academy of Otolaryngology-Head and Neck Surgery Breakfast Meeting
F. Thomas Sporck, M.D., presiding
Main Dining Room,

9:00-12:00 WV Section on Dermatology Business Meeting
Charles L. Yarbrough, M.D., presiding, Virginia Room

8:30-2:00 Registration—Exhibit Center Foyer
Exhibit Visitation

Second General Session
Governor's Hall

8:45 Call to Order and Welcome
Michael M. Stump, M.D.
Invocation
"Update on Cancer Management 1991"
Thomas H. Chang, M.D., Moderator

8:45 "Non-Small Cell Lung Cancer"
John D. Hainsworth, M.D., Associate Professor of Medicine, Division of Oncology, Vanderbilt University Medical Center

9:30 "The Treatment of Breast Cancer"
James K. Weick, M.D., Chairman, Department of Hemolotology and Medical Oncology, Cleveland Clinic

10:15 BREAK—Presentation of Trophies and Door Prizes

10:45 "Current Management of Rectal Cancer"
Victor W. Fazio, M.D., FRACS, FACS, Chairman, Department of Colorectal Surgery, The Cleveland Clinic Foundation

11:30 Questions and Answers

12:00 Adjournment

Friday Afternoon, August 16

12:00 WVSMA Cancer Committee Luncheon Meeting
Catalino B. Mendoza, Jr., M.D., presiding
Spring Room

12:00 WV Gastroenterology Society Luncheon and Scientific Meeting
Brittain McJunkin, M.D., presiding, Chesapeake Bay
"Non-Cardiac Chest Pain"
Richard Wright, M.D., Associate Professor of Medicine, University of Louisville School of Medicine, Louisville, KY

12:00 WV American College of Emergency Physicians Luncheon
Richard A. Capito, M.D., presiding, Hayes Room

12:00 WV Chapter of American Academy of Pediatrics
Paul J. Jakubec, M.D., presiding, Grant Room

12:00 WV Psychiatric Association Luncheon
Lee Neilan, M.D., presiding, Jackson Room

12:00 WV Academy of Ophthalmology Luncheon, James Genin, M.D., presiding, Lee Room

12:00 West Virginia Medical Institute Board of Trustees Luncheon Meeting
Harry S. Weeks, Jr., M.D., presiding, Wilson Room

12:30 WVSMA Publications Committee Meeting Luncheon
Stephen D. Ward, M.D., presiding, Washington Room

1:00 WV Academy of Ophthalmology Scientific Meeting, James Genin, M.D., presiding, Grant Room
"Overview of Diabetic Retinopathy Treatment"
Judie Charlton, M.D., WVU Department of Ophthalmology, WVU Health Sciences Center, Morgantown

1:00 WV Section on Dermatology Scientific Meeting
Charles L. Yarbrough, M.D., presiding,
Virginia Room

"Dermatological Surgery"
John Skouge, M.D., Clinical Professor of Dermatology, Johns Hopkins, Lutherville, MD

"Contact Dermatitis"
William Jordan, M.D., Clinical Professor of Dermatology, Richmond, VA

1:00 WV American College of Emergency Physicians Scientific Meeting
Richard A. Capito, M.D., presiding
Hayes Room

"Patients Taking Steroids: If They're On, Take Them Off, If They're Off, Put Them On"
Frederick "Rick" C. Blum, M.D., Assistant Professor of Surgery, WVU Hospitals, Inc., Morgantown

1:00 WV Psychiatric Association Business Meeting
Lee Neilan, M.D., presiding, Jackson Room

1:00 WV Society of Physical Medicine and Rehabilitation Meeting
Kenneth C. Wright, M.D., presiding
Tyler Room

1:00 WV Orthopedic Society Scientific Meeting
Michael O. Fidler, M.D., presiding
Van Buren Room
"Orthopaedic Surgeon's Role in Preventing Disability from Discogenic Low Back Pain"
Henry L. Feffer, M.D., Professor of Orthopaedic Surgery, Georgetown University School of Medicine, Washington, DC

2:00 WV Psychiatric Association Scientific Meeting
Lee Neilan, M.D., presiding, West Virginia Room
"Stigma of Seeking Psychiatric Treatment Complicated by the Patient's Concerns About Newer Antidepressants"
Elizabeth Bowman, M.D., Assistant Professor of Psychiatry, Indiana University School of Medicine, Indianapolis, IN

2:00 WV American College of Emergency Physicians Business Meeting
Richard A. Capito, M.D., presiding, Hayes Room

2:00 West Virginia Chapter, AAFP, Caucus
William B. Ferrell Jr., presiding, Theatre

2:00 WV Orthopedic Society Business Meeting
Michael O. Fidler, M.D., presiding
Van Buren Room

2:00 WV Academy of Ophthalmology Business Meeting
James Genin, M.D., presiding, Lee Room

4:00 1992 Annual Program Committee Meeting
Jackson Room

4:00 WV Psychiatric Association Reception
West Virginia Room

6:00 WVU and MU Alumni Cocktail Party
Cameo Ballroom

6:00 Office of Medical Alumni Relations and MCV Alumni Association Cocktail Party, Spring Room

9:00 Cabaret Dance, Music provided by "Southwind," Colonial Hall

9:30 After Dinner Speaker, "The Good Humor Man," James R. Craig, Springfield, MO, Colonial Hall

Saturday Morning, August 17

7:30 WV Radiological Society Breakfast/Scientific Meeting, Gary Marano, M.D., presiding, Lee Room
"Screening Mammography vs. Diagnostic Mammography"
Gary Price, Director of Government Relations, American College of Radiology, Reston, VA

7:30 Kanawha County Caucus Breakfast
William B. Ferrell, Jr., presiding, Hayes Room

8:30 WV Radiological Society Business Meeting
Gary Marano, M.D., presiding, Lee Room

8:15-9:30 Delegate Registration, Chesapeake Hall Foyer

8:45 WVSMA Second Session House of Delegates
Chesapeake Hall

Call to Order and Welcome—
Michael M. Stump, M.D., President

Presentation of Colors

Invocation, Laurie Marie Stump

Reaffirmation

Necrology Report

Introduction of 1991-92 WVSMA Auxiliary President

9:00 "Thomas L. Harris Address"

"The Physician As a Caring Citizen: Being More Than Just Good"
John M. Tew, Jr., M.D., Cincinnati, Ohio

9:45 Stretch and Reconvene

Business Meeting
Report of the Constitution and ByLaws Committee
Election of Officers

11:30 Recess for Lunch

Saturday Afternoon, August 17

12:00 Past Presidents, Visiting State Presidents and 50 Year Graduates Luncheon
Michael M. Stump, M.D., President, and Derrick L. Latos, M.D., Council Chairman, Co-hosts, Taft Room

11:45 Sports Medicine Luncheon
David W. Avery, M.D., presiding, Lee Room

1:00 Reconvene Second Session of the House of Delegates, Chesapeake Hall
Michael M. Stump, M.D., presiding

Special Recognition of Association Past Presidents

2:30 BREAK

Business Meeting continued
Resumption of Elections (if necessary)
Report of WVSMA Resolutions Committee
Installation of Officers

Oath of Office and Presidential Address, Constantino Y. Amores, M.D.

4:00 "Wild, Wonderful West Virginia"

Adjournment

6:30-7:30 Reception Honoring Newly Installed Officers of WVSMA and Auxiliary
Hosted by Charleston Area Medical Center, Phillip H. Goodwin, President, Chesapeake Terrace

1991-92 DELEGATES/ALTERNATES

BOONE (2)—Robert B. Atkins and Manuel T. Uy, Madison

BROOKE (2)—***Delegates:*** William G. Bell and William T. Booher, Jr., Wellsburg.
Alternates: Patsy P. Cipoletti, Jr., Wellsburg; and Rogelio Velarde, Follansbee.

CABELL (10)—***Delegates:*** Charles Abraham, Dennis M. Burton, John Hunt, David Hurry, William Lavery, Joseph LoCascio, Philip Stevens, Mabel Stephenson, Joseph Touma and Charles Yarbrough, Huntington.
Alternates: Paul Blair, Albert Esposito, Gary Gilbert, Jane Kurucz, Robert Marshall, Carl McComas, Louis Molina, James Morris, William L. Neal and Charles Turner, Huntington.

CENTRAL WV (3)—***Delegates:*** Rudy Pascasio and Frank Scattaregia, Weston; and Rigoberto Ramirez, Buckhannon.
Alternates: Clemente Diaz, Richwood; Joe Reed, Buckhannon; and Art Sabio, Sutton.

EASTERN PANHANDLE (4)—***Delegates:*** Edward Pinney, Keith Recht, Robert S. Strauch and C. Vincent Townsend, Martinsburg.
Alternates: Ramanujam Eyunni, Harvey Reisenweber and Francisco Sabado, Martinsburg.

FAYETTE (2)—***Delegates:*** Fred Akerberg, Charlton Hts.; and Sam Davis, Montgomery.
Alternates: Miraflor Khorshad, Summersville; and Adin Timbayan, Montgomery.

GREENBRIER VALLEY (3)—***Delegates:*** Romeo Endacot, Robert Scott and Stephen Thilen, Lewisburg.
Alternate: Robert A. Shirey, Lewisburg.

HANCOCK (3)—***Delegates:*** Lubin C. Alimario, Timothy Brown and Robert Solomon, Weirton.

HARRISON (4)—***Delegates:*** Chinmay K. Datta, Erlinda L. De La Pena, Clarksburg; Sidney Jackson and Douglas McKinney, Bridgeport.
Alternates: Thomas Chang, Ray A. Harron and Saad Mossallati, Bridgeport; and Charles Lefebure, Clarksburg.

KANAWHA (14)—***Delegates:*** Richard Capito and W. Alva Deardorff, South Charleston; Nicholas Cassis, Gene Cordell, Donald Farmer, Sherman E. Hatfield, Fred Holt, James Kessel, Jim Mangus, John Markey, William G. Sale, Tom Sporck and Ronald L. Wilkinson, Charleston; and John V. Merrifield, Dunbar.
Alternates: R. David Allara, Clinton A. Briley, Jr., Graciano E. Cendana, Robert Clubb, Larry Curnutte, Joseph Farris, David Gray, Michael O. Fidler, Tony Majestro, Jack Pushkin, Joseph Skaggs, and Kimberly Skaff, Charleston; and B. H. Avashia and Steve Perkins, South Charleston.

LOGAN (3)—***Delegates:*** Judith Brendemuehl and Rodney L. Stephens, Logan; and Thomas P. Long, Man.
Alternates: Harry Fortner and Raymond Rushden, Logan; and Enrico V. Rallos, Gilbert.

MARION (3)—Names not submitted.

MARSHALL (3)—***Delegates:*** Kenneth J. Allen, Glen Dale; Jesus Ho and Phillip B. Mathias, Moundsville.
Alternates: T. O. Dickey, Moundsville; David Nally and Howard Neiberg, Glen Dale.

MASON (2)—***Delegates:*** Mahendra Shah and Shrikant Vaidya, Point Pleasant.

MCDOWELL (2)—***Delegates:*** Alexander Herland and Charles E. Michaelis, Welch.
Alternates: Charito Flores and Muthusami Kuppusami, Welch.

MERCER (5)—Names not submitted.

MONONGALIA (4)—***Delegates:*** Carole Boyd, Douglas Glover, Donald Seibert and Jeffrey Stead, Morgantown.

OHIO (9)—***Delegates:*** Robert Altmeyer, Dennis Burech, James Comerci, Terry Elliott, Bart Heischfield, John Holloway, Dennis Neiss, Bruce Walmsley and Daniel Wilson, Wheeling.

PARKERSBURG ACADEMY (7)—***Delegates:*** Bill M. Atkinson, John E. Beane, Humberto Escandon and Rutherford C. Sims, Parkersburg; David W. Avery and Frank Schwartz, Vienna.

POTOMAC VALLEY (2)—***Delegates:*** Carl Liebig and Paul Healy, Keyser.
Alternates: James Bosley and David Chapman, Keyser.

PRESTON (2)—***Delegates:*** Paul Getty and John Keefe, Kingwood.
Alternate: Michael Schwarzenberg, Kingwood.

PUTNAM (2)—Names not submitted.

RALEIGH (7)—***Delegates:*** M. Jamil Ahmed, Ahmed D. Faheem, Wallace Johnson, Lamberto Maramba, Robert P. Pulliam, Iligino Salon and William A. Scaring, Beckley.
Alternates: William Covey, Jr., C. Richard Daniel, Jr., Prospero Gogo, Mario Ramas and Syed Zahir, Beckley; Lewis Fox, MacArthur; and Joseph Golden, Sophia.

SOUTH BRANCH VALLEY (2)—***Delegates:*** Anil Makani and Larry Rogers, Petersburg.

SUMMERS (2)—Names not submitted.

TUG VALLEY MEDICAL ASSOCIATION (2)—***Delegates:*** Theodore Cherukuri and Bapuji Narra, Williamson.
Alternate: Rano Bofill, Williamson.

TYGART'S VALLEY (2)—***Delegates:*** Fouad H. Abdalla, Elkins; and Karl J. Myers, Jr., Philippi.
Alternate: Gene Harlow, Grafton.

WESTERN (2)—***Delegates:*** Herminio Gamponia, Spencer; and James Kessel, Ripley.

WETZEL (2)—Names not submitted.

WYOMING (2)—Names not submitted.

Official Program

67th Annual Meeting

West Virginia State Medical Association Auxiliary

August 14-18, 1991

The Greenbrier, White Sulphur Springs, WV

Wednesday Afternoon
August 14

1:00-5:00 Registration*—Main Lobby
EVERYONE MUST BE REGISTERED TO PARTICIPATE IN THE BUSINESS SESSIONS AND RECREATIONAL ACTIVITIES.

3:30-5:30 Pre-Convention Board Meeting
Mrs. C. Vincent Townsend, President, presiding
Fillmore Room

Wednesday Evening

6:30-7:30 WVSMA Presidential Reception
Taft Foyer

Thursday Morning
August 15

8:30-3:00 Registration—Main Lobby

9:30-12:00 WVSMA Auxiliary House of Delegates
Mrs. C. Vincent Townsend, President, presiding
Fillmore Room

Invocation
Mrs. Charles E. Turner, Past President

Pledge of Allegiance to the Flag of the United States of America
Mrs. Iligino Salon, Vice President

Pledge of Loyalty
Mrs. Robert D. Altmeyer, President-Elect
"I pledge my loyalty and devotion to the American Medical Association Auxiliary. I will support its activities, protect its reputation and ever sustain its high ideals."

Introduction of Honored Guests and Past State Presidents

In Memorium
Mrs. Joe N. Jarrett, Chairman, Necrology

Introductions:
John J. Ring, M.D., President AMA
Michael M. Stump, M.D., President WVSMA
George Rider, Executive Director WVSMA
Jim C. Barnett, M.D., President SMA

Introduction of 1991 Convention Chairmen
Mrs. M. Bruce Martin, Chairman
Mrs. Robert A. Shirey, Vice-Chairman

Roll Call of Delegates
Mrs. Robert Strauch, Recording Secretary

Credentials and Registration
Mrs. M. Bruce Martin, Convention Chairman

Convention Rules of Order and Program
Mrs. M. Bruce Martin, Convention Chairman

Appointment of the Reading Committee

1990 Convention Reading Committee Report
Mrs. Harry S. Weeks, Chairman

Report of the Treasurer
Mrs. Harvey Reisenweber

Reports of Officers and Committee Chairman**

Presentation of Regional Directors
Northern—Mrs. Gus Mouhlas
Eastern—Mrs. James D. Helsley
Southern—Mrs. William A. Scaring
Western—Mrs. Robert W. Lowe
Central—Mrs. David B. Gray

Reports of County Presidents

Pre-Convention Board Meeting Recommendations

Unfinished Business

Appointment of Tellers

Election of the 1992 Nominating Committee

Remarks—Mrs. C. Vincent Townsend, President

Introduction of Speaker
Mrs. T. Keith Edwards, Eastern Region Vice President AMAA

Address—Mrs. Gary F. Strebel, President AMAA

Announcements

Adjournment

Thursday Afternoon

1:30 Tennis Tournament
Mrs. William A. Scaring, Chairman

2:00 Putting Tournament
Mrs. Clinton A. Briley, Jr., Chairman

3:00 WESPAC Meeting
Esther Weeks, Chairman, presiding
Fillmore Room

6:30-7:30 Reception, Colonial Terrace

Friday Morning
August 16

8:00 Past President's Breakfast —Washington Room

8:00-11:00 Registration—Main Lobby

9:00-12:00 WVSMA Auxiliary House of Delegates
Mrs. C. Vincent Townsend, President
Fillmore Room

Introduction of Honored Guests

Roll Call of Delegates
Mrs. Robert S. Strauch, Recording Secretary

Credentials and Registration
Mrs. Robert A. Shirey, Convention Vice President

Report of Convention
Mrs. M. Bruce Martin, Convention Chairman

Report of Press and Publicity
Mrs. Mark E. Meany, Chairman

Recognition of Medical School Grants
Robert D'Alessandri, M.D.,
Dean WVU School of Medicine
Charles H. McKown Jr., M.D.,
Dean Marshall University School of Medicine

Presentation of AMA-ERF Awards
Mrs. James D. Helsley, Chairman
Mrs. Mark E. Meany, Vice Chairman

Presentation of Membership Awards
Mrs. Robert D. Altmeyer, President-Elect,
Chairman of Membership

Auxilian and Auxiliary Award
Mrs. Michael M. Stump, Chairman of Awards

SMAA Doctors Day Awards
Mrs. Paul E. Gordon, SMAA Councilor

Introduction of Speaker
Mrs. Paul E. Gordon

Address
Mrs. Jim C. Barnett, President SMAA

New Business

Report of the Tellers
Mrs. Wallace Johnson

Report of the 1991 Nominating Committee
Mrs. Edward M. Spencer
Immediate Past President, Chairman

Election of Officers

Installation of Officers
Mrs. Gary F. Strebel, President AMAA

Presentation of President's Pin and Gavel
Mrs. C. Vincent Townsend

Presentaton of Past President's Pin
Mrs. Edward M. Spencer

Inaugural Address
Mrs. Robert D. Altmeyer

Announcements

Adjournment Sine Die

Friday Afternoon

12:30 President's Luncheon—Crystal Room

2:00 Bridge Tournament
Mrs. Ray A. Harron, Chairman
Trellis Lobby

Friday Evening

9:00 Entertainment—Chesapeake Hall

Saturday Morning
August 17

10:00 Post Convention Board Meeting
Fillmore Room

Saturday Evening

6:30-7:30 Reception Honoring Newly Installed Officers of WVSMA and WVSMAA—Chesapeake Terrace

*Registration fee is $5.00.

**These reports will not be read but are published in the 1991 Annual Report Book.

Acknowledgements

Special appreciation goes to the following businesses, schools and associations who have contributed grants or other support for this year's Annual Meeting. Their support makes the educational emphasis of the meeting possible:

The Chapman Printing Company
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West Virginia University CME Department
West Virginia University School of Medicine Alumni

1991 ANNUAL MEETING EXHIBITS
COMMERCIAL AND SCIENTIFIC/EDUCATIONAL

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Joyce Zinn

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WEST VIRGINIA STATE MEDICAL ASSOCIATION AUXILIARY

Judy Bofill, Prudy Tordilla, Siromani Bellam

WHITBY PHARMACEUTICALS

Steve Stephens, Chris Gaston, Russ Bergstrom

WVU ALUMNI ASSOCIATION*

WVU HEALTH SCIENCES CENTER

Kari Long, Cynthia Kemp, Chris Burnside, Virginia Hunt

WYETH-AYERST/A.H. ROBINS

Mark Bowling, Theodore Marchal, William Collier

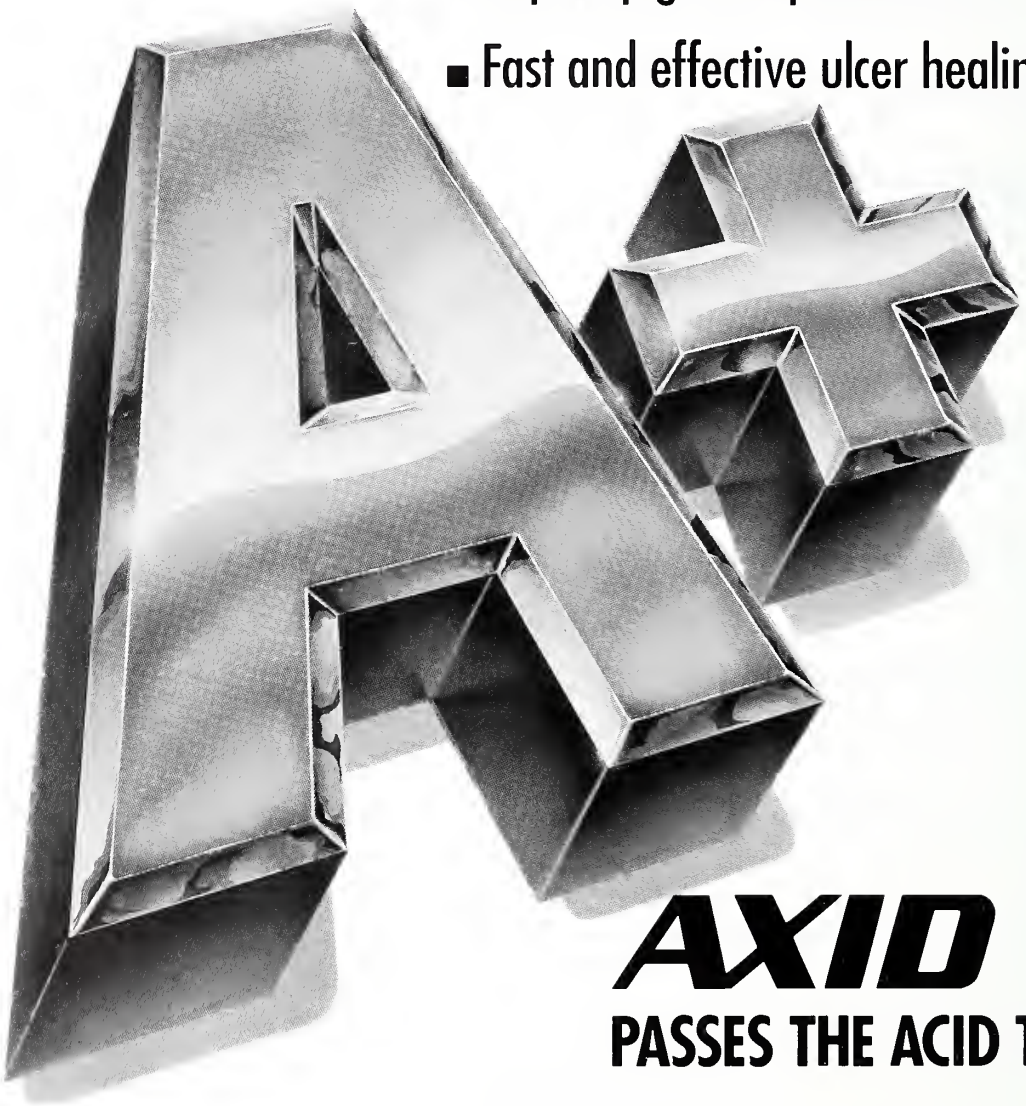
*Exhibitors Names Not Available at Press Time

For excellent response in the treatment of duodenal ulcers...

AXID® nizatidine

has the right answers

- Rapid epigastric pain relief[1,2*]
- Fast and effective ulcer healing[2,3,4]



AXID
PASSES THE ACID TEST

*Most patients experience pain relief with the first dose.

See adjacent page for references and brief summary of prescribing information.

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AXID® (nizatidine capsules)

Brief Summary. Consult the package insert for complete prescribing information.
Indications and Usage: 1. *Active duodenal ulcer*—for up to 8 weeks of treatment. Most patients heal within 4 weeks.

2. *Maintenance therapy*—for healed duodenal ulcer patients at a reduced dosage of 150 mg h.s. The consequences of therapy with Axid for longer than 1 year are not known.

Contraindications: Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H_2-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H_2-receptor antagonists.

Precautions: *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix® may occur during therapy.

Drug Interactions—No interactions have been observed with theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,900 nizatidine patients and over 1,300 on placebo, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events were due to the drug.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H_2-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H_2-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis does not substantially increase clearance of nizatidine due to its large volume of distribution.

PV 2091 AMP
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References
1. Data on file, Lilly Research Laboratories.
2. *Scand J Gastroenterol.* 1987;22(suppl 136):61-70.
3. *Scand J Gastroenterol.* 1987;22(suppl 136):47-55.
4. *Am J Gastroenterol.* 1989;84:769-774.

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WEST VIRGINIA UNIVERSITY HEALTH SCIENCES CENTER

Compiled from material furnished by the West Virginia University Health Sciences Center News Service, Morgantown.

WVU to Manage Cabin Creek Clinic

Governor Gaston Caperton recently announced an agreement which will allow residents of eastern Kanawha County to return to the Cabin Creek Clinic for medical services.

The West Virginia University School of Medicine will operate the clinic as a clinical teaching facility. Medical students and faculty from WVU, Marshall University School of Medicine and the West Virginia School of Osteopathic Medicine will participate in programs at the clinic which reopened on June 25.

The agreement negotiated by Caperton has been approved by both the Cabin Creek Health Association, which formerly operated the clinic, and the Shonk Land Company, which owns the clinic building.

"We see this clinic as an important addition to our teaching facilities," said Dr. Robert D'Alessandri, dean of the WVU School of Medicine. "But more importantly to the people of the Upper Kanawha Valley, it is a key institution in their primary health care system."

The clinic, established in the 1970s, closed earlier this year after it lost a federal grant and was unable to make liability insurance payments.

Under the terms of the agreement, WVU will assure that medical professionals are available at the clinic on a regular schedule, and will assume complete responsibility for the financial operations of the clinic. WVU is not responsible for the debts of the clinic's previous operators.

Governor Caperton raised $100,000 in private donations for the reopening of the clinic and half of this amount will be allocated for renovations of the building. WVU and the governor intend to work together to assure that the clinic is recertified for federal assistance, Dr. D'Alessandri said.

Dental School Dean Named VP of Health Sciences Center

W. Robert Biddington was appointed vice president for health sciences of West Virginia University on July 1.

Dr. Biddington, dean of WVU's School of Dentistry since 1968, is past president of the American Association of Dental Schools and of the American College of Dentists. He has been associated with WVU since 1959, when he joined the faculty of the School of Dentistry as chairman of the department of endodontics.

Dr. Biddington will succeed John E. Jones, M.D., who leaves WVU this summer for a post at Virginia Commonwealth University. Dr. Biddington has announced his intention to retire in 1992, and WVU officials expect to launch a nationwide search for a new vice president shortly.

This is the second time Dr. Biddington has been asked to lead the Health Sciences Center. He served as interim chief academic and administrative officer for the Center in 1981-82. He was also interim provost of WVU in 1979-80.

McMillan Accepting New Position in North Carolina

William O. McMillan Jr., M.D., associate vice president for health sciences at West Virginia University's Charleston division, is accepting a new position on September 1, as executive director of the Area Health Education Center (AHEC) in Wilmington, N.C.

Dr. McMillan joined the Charleston division in 1973 as a clinical associate professor of medicine, specializing in gastroenterology. He held various academic ranks at WVU over the years while continuing in private practice in his area of specialization.

Prior to accepting the associate vice president's post in 1985, Dr. McMillan served as director of the department of medical education at the Charleston Area Medical Center from 1980 to 1985.

"Bill McMillan is that special combination of caring physician, accomplished administrator and respected community citizen," said President Neil Bucklew. "West Virginia and WVU will miss him."

National Meeting of Ophthalmologists Held in Morgantown

The Board of Directors of the American Academy of Ophthalmology (AAO) met June 21-23 at the Lakeview Resort and Conference Center.

The meeting was hosted by Dr. George W. Weinstein, chair of the department of ophthalmology at West Virginia University and president of the AAO. The Morgantown meeting was devoted to planning and review of the Academy's academic and socio-economic programs.

The board members toured the University Eye Center in WVU's Physician Office Center during the meeting.

Telethon Raises $261,000 for Children's Hospital

Residents of West Virginia and adjoining states donated $261,681 to the WVU Children's Hospital during the Children's Miracle Network Telethon, June 1-2.

The 23-hour telethon, broadcast in West Virginia by WDTV, Clarksburg; WVAH, Hurricane; and WTOV, Weirton-Steubenville, was a part of a national fundraising effort by 160 children's hospitals.

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MU School Of Medicine News

MARSHALL UNIVERSITY

Compiled from material furnished by the Office of University Relations, Marshall University.

Special Program Offered for Dyslexic Medical Students

Doctors and medical students from across the United States are at Marshall University this summer for Dr. Barbara Guyer's one-of-a-kind program which helps them overcome the effects of dyslexia and other learning disabilities.

Called Medical H.E.L.P., the program teaches participants to manage their time, improve their reading and learning efficiency, apply critical thinking skills and sharpen their test-taking skills, according to Dr. Guyer, who is a program director and professor of education at MU. The program is a special adaptation of Marshall's Higher Education for Learning Problems program.

This year's nine Medical H.E.L.P. participants include a practicing surgeon and radiologist as well as medical students from California, Kansas, West Virginia, New York and Puerto Rico. Most participants in the program have dyslexia and in addition to their high intelligence, have other qualities in common.

"Research shows that dyslexic people have special skills: they're usually more verbal, and often more creative, sympathetic, athletic and math-oriented," Dr. Guyer said. "One of my first students is a perfect example and shows that these individuals can excel as doctors. About six years ago, the dean of Marshall's medical school called because a very bright, motivated medical student was failing. He asked me to test the student for learning disabilities, and it turned out he had a genius-level IQ but high-school reading skills."

Dr. Guyer started working with "John," and by the end of the summer she also was helping three other students improve their reading speed and comprehension. The month-long program now draws about 15 participants, including practicing doctors and medical residents as well as medical students who work individually and in small groups with two teachers who have master's degrees in learning disabilities.

The program taps high-technology learning techniques such as computerized vocabulary-building and speed-reading programs. In addition, those enrolled in the Medical H.E.L.P. project also spend time in stress management sessions.

"Dyslexic medical students have had no experience dealing with failure," Dr. Guyer explained. "Many were valedictorians, with difficult majors and 4.0 grade point averages, who got to medical school and failed miserably. A few have told me they were suicidal."

Once the program is completed, Dr. Guyer urges participants to call in regularly so she can monitor their progress. "If they start to slip, they'll often call in for a refresher," she explained. "Most of them just need encouragement and to be reminded of the skills they've learned and the positive mental outlook they need to have."

So far the program has a nearly 100 percent success rate, and Dr. Guyer is especially proud that John excelled in medical school and was ultimately chosen for a highly competitive plastic surgery residency program. In fact, the residency director told John that his success in overcoming dyslexia helped win him the position. On an American Board of Surgery exam, he scored in the top 10 percent in the nation.

"The Medical H.E.L.P. program is probably the most rewarding thing I've been involved in," Dr. Guyer said. "These people are so gifted, and you know that if they have to leave medical school, they'll have some deep emotional scars."

Medical Alumni to Honor Dr. Lotspeich

Dr. Frederick J. Lotspeich

Frederick J. Lotspeich, Ph.D., who perhaps has taught more West Virginia physicians than any other medical school faculty member, will be honored during Medical Alumni Weekend activities, September 28-29.

Dr. Lotspeich is retiring as professor and chairman of biochemistry on September 1. He began his career as an assistant professor of biochemistry at the West Virginia University Medical Center in 1956 and rose to the rank of professor during his 21 years there. Dr. Lotspeich was named to his current post as chairman of Marshall's Department of Biochemistry in 1977.

"We want to invite all of Fred's colleagues and former students to join us in honoring him," said Dean Charles H. McKown Jr. "He's truly an institution in West Virginia medical education."

Before returning to the state to teach, Dr. Lotspeich had been a research chemist for E.I. DuPont and an assistant professor of chemistry and acting chairman at Simpson College. A native of Keyser, Dr. Lotspeich received his bachelor's and master's degrees from WVU and his doctorate from Purdue University.

Details about Medical Alumni Weekend events are available by contacting Peggy Theis at 696-7246.

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You may serve near your home, at times convenient for you, or at Army medical facilities in the United States and abroad. There are also opportunities to attend conferences and participate in special training programs, such as the Advanced Trauma Life Support Course.

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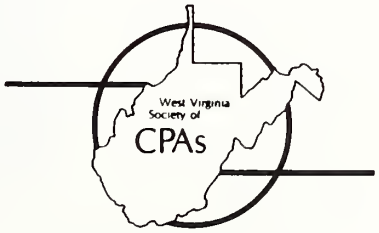

New Members

We are pleased to welcome the following new members:

Christine A. Bezouska, M.D.
WVU Medical Center
Dept. of Anesthesiology
Morgantown, WV 26506

Jeffrey Shear, M.D.
P.O. Box 2515
Elkins, WV 26241

Joseph L. Voelker, M.D.
WVU Medical Center
Dept. of Neurosurgery
Morgantown, WV 26506

WESPAC Members

We wish to thank the following individuals for their recent contributions to WESPAC:

Physicians

Boone
*Ernesto T. Yutiamco

Cabell
*Willard F. Daniels Jr.
*R.A. Kayser Jr.
*Craig M. Morgan
William L. Neal
Bruce A. Ratliff
*Jose I. Ricard
Gary L. Ripley
Tara C. Sharma
John P. Shiels
Phillip R. Stevens
*Jack R. Steel
*S. Kenneth Wolfe
*Charles E. Turner

Eastern
William F. Schrantz
Edward E. Volcjak

Hancock
Antonia S. Licata

Harrison
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James A. Genin
Brenda L. Holbert
J. Michael Holbert
*M.V. Kalaycioglu

Kanawha
R. David Allara
Gina R. Busch
*William H. Carter
*Ronald E. Cordell
Jan H. Cunningham
*Thomas R. Douglass
*Edmundo E. Figueroa
Mallinath Kayi
*James W. Kessel
*Chandra M. Kumar
*Romeo Y. Lim
*Ronald McCowan
*Fred T. Pulido Jr.
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Obituaries

William Paul Bradford, M.D.

Dr. William Paul Bradford, M.D., 79, of Moundsville, died May 4 at Reynolds Memorial Hospital in Glendale.

Born in Sistersville, Dr. Bradford graduated from Washington and Jefferson College in Washington, Pa., where he was a member of Lambda Chi Alpha Fraternity. He received his medical degree from Temple University in Philadelphia and did an internship at Western Pennsylvania Hospital in Pittsburgh and postgraduate work at Cook County Hospital in Chicago.

Dr. Bradford served as chief of staff at Reynolds Memorial Hospital and on the board of directors at the former First National Bank in Moundsville. He was a member and past president of the Marshall County Medical Society and had been a member of the WVSMA since 1940.

Dr. Bradford served in the Army during World War II on Eisenhowers' staff for the Supreme Headquarters Allied Forces in Europe.

Survivors include his son, William Paul Bradford Jr. of Lancaster, Ohio; two daughters, Suzanne Snyder of Lewisburg, W.Va., and Judith Ann Bradford of Fredericksburg, Va.; six grandchildren and a great-granddaughter.

Antonio Palladino, M.D.

Dr. Antonio Palladino, M.D., 63, of Morgantown died on June 16 at his home.

Born in Teramo, Italy, Dr. Palladino received his medical degree from the University of Naples. He did his residency in obstetrics/gynecology at Baltimore City Hospital, University of Maryland Division in Baltimore, and did a clinical research fellowship at McGill University in Montreal.

Dr. Palladino served on the faculty of the West Virginia University School of Medicine from 1964-74, where he reached the rank of professor. A clinical professor of obstetrics/gynecology at WVU Hospital, Dr. Palladino also was on the attending staff at Monongalia General Hospital. Since 1974, he had been in private practice with Drs. Walter A. Bonney and M. Kamal Behnam in Morgantown.

Certified by the American Board of Ob/Gyn and the Italian Board of Ob/Gyn, Dr. Palladino was a member of the American College of Ob/Gyn, the American Medical Association, the Association of Obstetricians/Gynecologists of Quebec, the Monongalia County Medical Society and the West Virginia State Medical Association.

Survivors include his wife, Adriana Del-Pozzo Palladino; two brothers, Dr. George Palladino of Monza, Italy, and Dr. Marco Palladino of Rome; and a sister, Dr Maria Dora Palladino of Naples, Italy.

County Societies

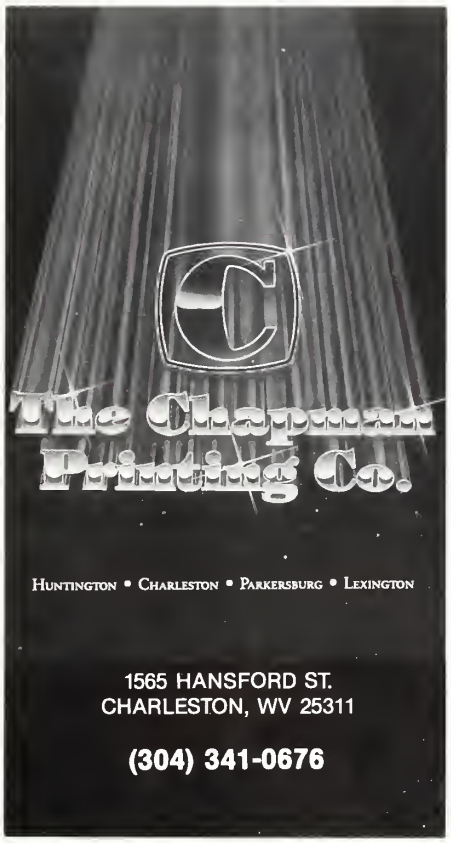
Boone

At their recent meeting, the members donated $2,600 to the American Heart Association to start a Heart Healthy program in the Boone County schools and made plans for these presentations.

Raleigh

The guest speaker for the June meeting was Dr. Robert D'Alessandri, dean of the West Virginia University School of Medicine, who spoke on "The Medical Crisis in West Virginia."

Dr. D'Alessandri discussed the Kellogg Foundation grant that had been awarded to the three medical schools, problems of access to health care and changes needed in medical education.



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PRECAUTIONS: General: Caution should be given to potential anticholinergic (drying) effects in patients with lower airway diseases, including asthma. Caution should be used in patients with cirrhosis or other liver diseases (See Clinical Pharmacology section). HISMANAL does not appear to be dialyzable. Caution should also be used when treating patients with renal impairment.

Information for Patients: Patients taking HISMANAL should receive the following information and instructions. Antihistamines are prescribed to reduce allergic symptoms. Patients should be questioned about pregnancy or lactation before starting HISMANAL therapy, since the drug should be used in pregnancy or lactation only if the potential benefit justifies the potential risk to fetus or baby (see Pregnancy subsection). Patients should be instructed 1) to take HISMANAL only as needed, 2) not to exceed the prescribed dose, and 3) to take HISMANAL on an empty stomach, e.g., at least 2 hours after a meal. No additional food should be taken for at least 1 hour post-dosing. Patients should also be instructed to store this medication in a tightly closed container in a cool, dry place, away from heat or direct sunlight, and away from children.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Carcinogenic potential has not been revealed in rats given 260x the recommended human dose of astemizole for 24 months, or in mice given 400x the recommended human dose for 18 months. Micronucleus, dominant lethal, sister chromatid exchange and Ames tests of astemizole have not revealed mutagenic activity. Impairment of fertility was not observed in male or female rats given 200x the recommended human dose.

Pregnancy: Pregnancy Category C: Teratogenic effects were not observed in rats administered 200x the recommended human dose or in rabbits given 200x the recommended human dose. Maternal toxicity was seen in rabbits administered 200x the recommended human dose. Embryocidal effects accompanied by maternal toxicity were observed at 100x the recommended human dose in rats. Embryotoxicity or maternal toxicity was not observed in rats or rabbits administered 50x the recommended human dose. There are no adequate and well controlled studies in pregnant women. HISMANAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. Metabolites may remain in the body for as long as 4 months after the end of dosing, calculated on the basis of 6 times the terminal half-life (See Clinical Pharmacology section).

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because certain drugs are known to be excreted in human milk, caution should be exercised when HISMANAL is administered to a nursing woman. HISMANAL is excreted in the milk of dogs.

Pediatric Use: Safety and efficacy in children under 12 years of age has not been demonstrated.

ADVERSE REACTIONS: The reported incidences of adverse reactions listed in the following table are derived from controlled clinical studies in adults. In these studies the usual maintenance dose of HISMANAL® (astemizole) was 10 mg once daily.

	Percent of Patients Reporting		
	Controlled Studies*		
ADVERSE EVENT	Hismanal (N = 1630) %	Placebo (N = 1109) %	Classical** (N = 304) %
Central Nervous System			
Drowsiness	7.1	6.4	22.0
Headache	6.7	9.2	3.3
Fatigue	4.2	1.6	11.8
Appetite increase	3.9	1.4	0.0
Weight increase	3.6	0.7	1.0
Nervousness	2.1	1.2	0.3
Dizzy	2.0	1.8	1.0
Gastrointestinal System			
Nausea	2.5	2.9	1.3
Diarrhea	1.8	2.0	0.7
Abdominal pain	1.4	1.2	0.7
Eye, Ear, Nose, and Throat			
Mouth dry	5.2	3.8	7.9
Pharyngitis	1.7	2.3	0.3
Conjunctivitis	1.2	1.2	0.7
Other			
Arthralgia	1.2	1.6	0.0

*Duration of treatment in Controlled Studies ranged from 7 to 182 Days
**Classical Drugs: Clemastine (N = 137); Chlorpheniramine (N = 100); Pheniramine Maleate (N = 47); d-Chlorpheniramine (N = 20)

Adverse reaction information has been obtained from more than 7500 patients in all clinical trials. Weight gain has been reported in 3.6% of astemizole treated patients involved in controlled studies, with an average treatment duration of 53 days. In 46 of the 59 patients for whom actual weight gain data was available, the average weight gain was 3.2 kg. Less frequently occurring adverse experiences reported in clinical trials or spontaneously from marketing experience with HISMANAL include: angioedema, bronchospasm, depression, edema, epistaxis, myalgia, palpitation, photosensitivity, pruritus, and rash. Marketing experiences include isolated cases of convulsions. A causal relationship with HISMANAL has not been established.

OVERDOSAGE: In the event of overdosage, supportive measures including gastric lavage and emesis should be employed. Cases of overdose have been reported from foreign marketing experience. Although overdoses of up to 500 mg have been reported with no ill effects, cases of serious ventricular arrhythmias, including Torsades de pointes, following overdoses of greater than 200 mg have been reported. Patients should be carefully observed and ECG monitoring is recommended in cases of suspected overdose. An appropriate antiarrhythmic treatment may be needed. HISMANAL does not appear to be dialyzable. Care should be taken not to exceed dosing recommended in the DOSAGE AND ADMINISTRATION section. Oral LD_{50} values for HISMANAL were 2052 mg/kg in mice and 3154 mg/kg in rats. In neonatal rats, the oral LD_{50} was 905 mg/kg in males and 1235 mg/kg in females.

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References: 1. Knight A. Astemizole—a new non-sedating antihistamine for hayfever. *J Otolaryngol* 1985;14(2):85-88. 2. Howarth PH, Holgate ST. Comparative trial of two non-sedative H_1 antihistamines, terfenadine and astemizole, for hay fever. *Thorax* 1984;39:668-672.

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

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References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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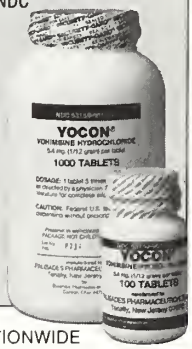

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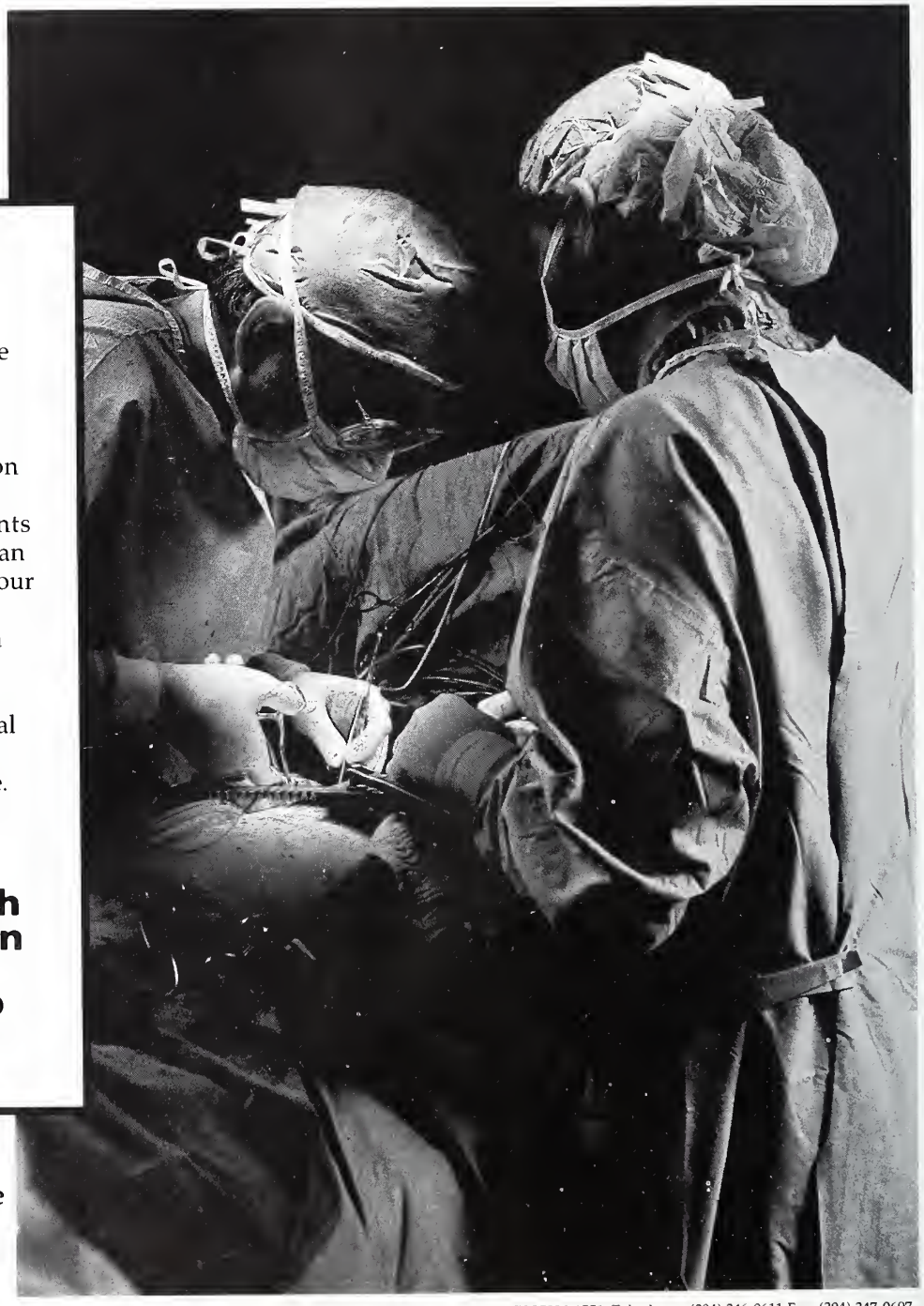

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West Virginia Medical JOURNAL

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The horses race to the finish line at Mountaineer Park in Chester, which is located in Hancock County. Photo courtesy *Larry Belcher, West Virginia Division of Tourism and Parks.*

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Management of Malignant Ventricular Arrhythmias Using Antitachycardia Devices

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Departments of Cardiovascular Surgery and Cardiology, Charleston Area Medical Center, Charleston

Abstract

Cardioverter defibrillators were implanted in 26 patients at Charleston Area Medical Center for management of cardiac arrest (7 patients), and drug refractory sustained ventricular tachycardia (19 patients). A variety of operative approaches and concomitant surgical procedures were utilized in the implantation of these devices. No operative deaths occurred. A superficial wound infection was the only operative complication. During the follow-up period (9.3 ± 5 months), 11 of 26 patients (46 percent) had a defibrillator discharge and one death occurred (3 percent), which was due to heart failure.

Patients with malignant ventricular arrhythmias may present with sustained monomorphic ventricular tachycardia with associated syncope, pre-syncope or without any associated symptoms. Unfortunately, cardiac arrest may be the initial presentation. The use of antitachycardia devices such as implantable cardioverter defibrillators and antitachycardia pacemakers has allowed physicians to more successfully treat patients with malignant ventricular arrhythmias. In a significant number of patients with these arrhythmias, such devices are now used as first-line therapy.

Introduction

Ventricular tachycardia (VT) usually precedes ventricular fibrillation (VF) during recorded episodes of sudden cardiac death (1). Preventing the recurrence of VT has until recently centered around the use of antiarrhythmic medications.

This approach has been, to a great degree, unsatisfactory in the patients with malignant ventricular arrhythmias who are at greatest risk for arrhythmia recurrence. While not playing a role in the prevention of malignant ventricular arrhythmias, devices such as antitachycardia pacemakers and implantable cardioverter defibrillators (ICDs) provide effective treatment (2-5).

Survival from sudden cardiac death recurrence has been improved by the implantation of an ICD (6). The one-year sudden cardiac death rate in patients implanted with an

Table

Pts.	age	sex	EF #	arrhythmia (at EPS)	heart Dz	drugs	shocks (total)	follow-up (months)
1	76	M	40	VT	CAD	Q,M	13	22
2	59	M	20	VT	CAD	A	22	22
3	67	M	25	VT	CAD	M	121	19
4	50	M	35	VT	CAD	A	7	14
5	63	F	64	VF	CAD	P		12
6	43	M	30	VT	CAD	P	1	11
7	56	M	25	VF	CAD	M		11
8	67	M	65	VF	NONE	P	1	10
9	66	M	35	VT	CAD	A		10
10	65	M	25	VT	CAD	A		9
11	56	M	35	VT	CAD	NONE		9
12	60	F	25	VF	DC	Eth	3	9
13	60	M	27	VT	CAD	NONE	1	7
14	71	M	50	VF	CAD	M		8
15	71	M	20	VT	CAD	A		7
16	62	F	50	VT	CAD	NONE		7
17	66	M	25	VT	CAD	P	1	6*
18	49	M	30	VF	CAD	M		6
19	65	M	33	VF	CAD	A		6
20	66	M	35	VT	CAD	NONE		3
21	67	M	25	VT	CAD	M	1	2
22	55	M	40	VT	CAD	Bblk		1
23	51	M	35	VT	DC	NONE		<1
24	46	M	35	VT	CAD	Bblk		<1
25	62	M	40	VT	CAD	Prpf	6	<1
26	69	M	29	VT	CAD	NONE		<1

LEGEND
A—amiodarone
Eth—ethmozine
Prpf—propafenone
M—mexilitine
Bblk—beta blocker
*—expired due to heart failure
Q—quinidine
CAD—coronary artery disease
P—procainamide
#—left ventricular ejection fraction
DC—dilated cardiomyopathy

ICD has been reported to be 0.9 percent while this rate at two and five years is 3.1 percent and 4.4 percent, respectively (7). In the absence of an ICD, or appropriately selected antiarrhythmic drug therapy, the rate of sudden cardiac death recurrence may be as high as 30 percent at one year or 45 percent at two years (8). Accordingly, worldwide implantation of these devices has increased significantly.

From March 1989 to February 1991, 26 patients were implanted with ICDs at the Charleston Area Medical Center (CAMC), Memorial Division. This report reviews this clinical experience and the use of devices to manage malignant ventricular arrhythmias.

Methods

From October 1989-February 1991, 200 electrophysiology studies were performed at CAMC. From these studies, 60 patients had a sustained ventricular arrhythmia induced including 56 patients having monomorphic VT and 4 having VF. Antiarrhythmic medications were used alone to suppress these arrhythmias in 36 patients based on the results of electrophysiologic testing. The remaining 24 patients were managed with antitachycardia devices and other non-pharmacologic treatments.

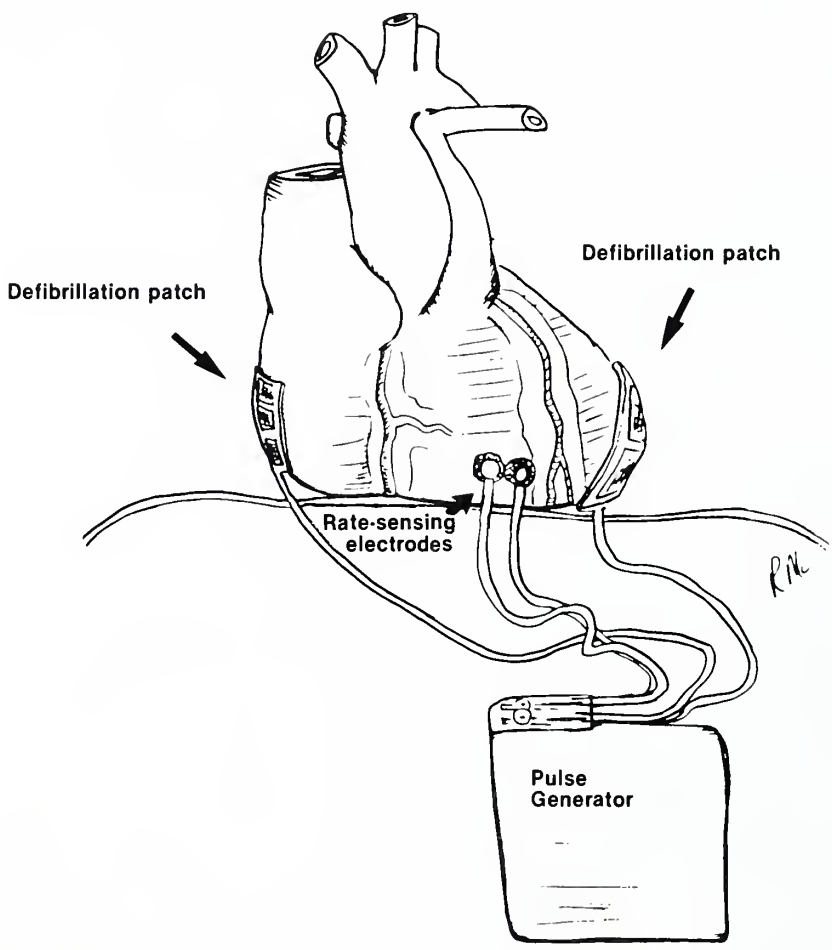
Cardioverter defibrillators were implanted in 26 patients (including two patients having ICD pulse generator replacement, alone) who had an episode of sudden cardiac death and/or drug refractory sustained ventricular tachycardia. There were 23 males and three females (Table 1). Patients' ages ranged from 43 to 76 years (mean 61 ± 8 years). Seven patients were survivors of a cardiac arrest and 19 presented with syncope and/or sustained monomorphic ventricular tachycardia.

Prior to surgical intervention, a complete cardiac evaluation, which included cardiac catherization and electrophysiologic study (EPS), was performed. Coronary artery disease was present in 24 patients while two patients had a dilated cardiomyopathy. The mean left ventricular ejection fraction for the entire group of patients measured 34 ± 11 percent.

The electrophysiology study protocol has been previously reported (9). Briefly, atrial pacing was performed to evaluate atrial, sinus and av nodal, and His-Purkinje electrical characteristics. The ventricular pacing protocol involved the introduction of single, double and triple extrastimuli at up to two right ventricular pacing sites. All patients were refractory to pharmacologic suppression of the induced arrhythmia. One survivor of sudden cardiac death with a dilated cardiomyopathy did not have a ventricular arrhythmia induced at electrophysiologic study, but was considered to be at sufficient risk of recurrence to warrant implantation of an ICD system.

Twenty-three of these patients underwent psychological evaluation prior to ICD implant due to the possible adverse psychological responses that may arise subsequently (10,11).

Figure 1. The IDC System



ICD Implantation

The ICD system is shown in Figure 1. A variety of operative approaches were used to facilitate implantation of the system. A median sternotomy approach was employed for primary system implantation and is required when implantation is combined with other open-heart procedures. A left lateral thoracotomy was utilized in patients having had previous open-heart surgery. Finally, a subzyphoid procedure using a vertical incision starting at the inferior sternum and extending inferiorally 6 cm. - 8 cm. provided sufficient exposure to implant two defibrillating patch electrodes and two myocardial sensing electrodes.

The following electrical evaluation was accomplished for all operative approaches. The rate sensing and defibrillating patch electrodes were tested for R-wave amplitude and duration, pacing thresholds (voltage and current), and resistance using a pacing systems analyzer (PSA). The amplitude and duration of the R-wave were verified by electrogram using a physiologic recorder. R-waves were measured for duration to prevent double counting of the heart rate by the ICD pulse generator. In addition, patients with implanted pacemakers (two dual and two single chamber) were tested with the pacemaker at maximal output in order to eliminate detection of a pacemaker stimulus by the ICD.

Defibrillation threshold (DFT) was defined as the least amount of energy (joules or J) required to terminate induced VF. Ventricular fibrillation was induced using AC current introduced via the rate sensing electrodes. An external cardioverter defibrillator (ECD) was then used to terminate the VF. The initial ECD test discharge was with 15J and, if successful, VF was again induced and a second test discharge was delivered at 10 or 15J. No energies below 10J were tested and, in general, no more than three test discharges were delivered via the ECD. Safety margins of >10J were sought for therapy. An ICD pulse generator would not be implanted if >20J were required to terminate VF.

The implanted patch and rate-sensing electrodes were then tunneled to the left paraumbilical region in all patients, except one. This patient had a previously implanted pacemaker at the site requiring implant of the defibrillator pulse generator in the right paraumbilical region. A magnet was then placed over the implanted pulse generators so that the audible tones could be used to assess for appropriate electrical connections and sensing.

All patients except three, had myocardial screw-in leads placed for rate sensing. These three patients had bipolar endocardial leads placed in the right ventricle. Two large patch defibrillation lead configurations were used in all patients except three who had a small/large patch configuration. The defibrillating patches were connected electrically so that the right ventricular patch was negative and the left ventricular patch was positive with the resultant current flow going from the right to the left ventricle (12). One patient treated with amiodarone had unacceptably high DFTs >25J). A spring defibrillating electrode was placed in addition to the two patch and rate sensing electrodes. No pulse generator was implanted. Two weeks later on return to the operating room, DFTs in a tripolar electrode configuration (spring and RV patch electrodes were electrically negative and LV patch electrode electrically positive) were found to be acceptable.

The ICD pulse generators were programmed to have cut-off rates of 150 to 180 beats/minute (mean 165 ± 7). The first shock energy was programmed to 26J in 12 patients and 30 in 15 patients based on the DFT. One patient had an ICD pulse generator implanted capable of delivering extremely low energy first shocks (0.1-30J). The first shock energy was programmed to 2J in this patient due to the presence of easily terminated VT.

The ICD pulse generators were left inactive while the patients were in the ICU and then activated for two to three days after the operation due to the possibility of atrial fibrillation causing an inappropriate ICD discharge. However, those patients undergoing pulse generator replacement only, or implant by a subxyphoid approach, had their ICDs turned on prior to leaving the operating room.

Antitachycardia Pacing

Of a total of four patients undergoing antitachycardia pacemaker testing, three had the device implanted and one of these was for VT treatment. One other patient had his VT treated temporarily using an external antitachycardia pacemaker. In addition to the required analysis for possible ICD-pacemaker interaction, implantation of the antitachycardia pacemaker required multiple VT inductions for determination of the most effective and rapid termination protocol. During VT, the pacemaker will deliver any number of pacing stimuli from 1-250 and in different programmable patterns to terminate the VT.

In diagnosing a tachycardia, the pacemaker takes advantage of the fact that tachycardias usually start abruptly, have stable rates and are usually sustained. Therefore the programmable detection criteria include high rate, suddenness of onset, rate stability, and sustained high rate. These four criteria can be combined to provide nine different tachycardia detection algorithms.

Statistical Methods

A CoStat computer software package was used for statistical analysis (13). Data are expressed as mean ± 1 standard deviation. Students' ± test was used to assess differences in means and P values of <0.05 were considered significant.

Results

Of 26 patients undergoing ICD implantation, eight had concurrent coronary artery bypass graft surgery. Left ventricular aneurysmectomy, endocardial mapping with cryoablation and subendocardial resection were performed in two patients. There were no surgical mortalities.

Final DFTs were <15J except in three patients in which it was >15J, but ≤20J. One patient had double counting of the rate sensing electrogram due to an electrogram duration of 140 milliseconds (ms) which is just at the refractory period of the ICD. This was corrected by mapping of the epicardial surface of the left ventricle to find a narrow electrogram and resulted in a measured electrogram duration of 132 ms and resolution of the double counting. Amiodarone was also discontinued with further shortening of the QRS duration expected.

Sixteen patients had a median sternotomy performed for implantation of the ICD system. Two patients underwent left thoracotomy and three patients had a left thoracotomy with associated mini-right thoracotomy. The subzyphoid approach was employed in three patients. Two patients having ICDs systems implanted at other centers had pulse generators

electively replaced while under local anesthetic. As with the ICD system implants, DFT testing was performed for determination of adequate defibrillation safety margins.

During the postoperative course, one patient developed a superficial wound infection without invasion into the lead system or pulse generator. The infection was treated successfully with antibiotics. No other patients experienced complications.

Pre-discharge electrophysiologic study was performed in all patients to verify device efficacy in terminating VF. Induced VF was terminated by the ICD with a single ICD discharge in all patients except for two. One of these patients required three shocks prior to termination of VF. This was thought to be due to an amiodarone related high DFT. Testing was repeated one month after discontinuation of amiodarone with termination of VF occurring after single ICD discharge. One other patient required two discharges for VF termination. This was corrected by programming to a higher ICD first shock energy (30J).

Nineteen patients were discharged from the hospital on antiarrhythmic medications while seven patients were not. The two patients who had operative mapping and arrhythmia surgery did not have inducible VT at pre-discharge electrophysiologic testing and, therefore, were not discharged on antiarrhythmic medications.

Follow-up

The mean follow-up has been for 9.3 ± 5 months (range 1-22 months). ICD discharges have occurred in 11 patients (46 percent). The mean number of discharges per patient is 12 ± 7 (range 1-22) excluding one patient who had 121 discharges over a follow-up of 19 months. These discharges were considered to be appropriate in all patients except one who was thought to have rate-crossover with sinus tachycardia exceeding the programmed cut-off rate of the ICD. This was evaluated by exercise stress testing and corrected by programming the ICD to a higher rate. One patient died of heart failure five months after ICD implant and he had experienced one ICD discharge during follow-up. There were no other deaths.

Further analysis of the ICD discharges revealed that the mean time from device implant to the occurrence of the first discharge was 2.8 ± 2 months. A comparison was then made between those patients having appropriate ICD discharges (10 patients) and those not having ICD discharges (13 patients) during the follow-up period. Those patients experiencing appropriate discharges had a mean ejection fraction of 34 ± 12 percent. The mean age is 61 ± 8 years and the follow-up period has been for 10.4 ± 6 months. Eight of these patients (80 percent) had inducible VT at EPS and nine of the patients were taking antiarrhythmic drugs. In the group not experiencing an ICD discharge, the ejection fraction measured 36 ± 12 percent, the mean age was 59 ± 8 years, and the follow-up period 7.6 ± 2 months. Five of the 13 patients (38 percent) in this group had induced VT at EPS. Eight of these patients were taking antiarrhythmic drugs. There were no significant differences in these parameters between the two groups ($p = >1.0$ for all compared parameters) except for a greater tendency for inducible VT in the group of patients having ICD discharges.

Discussion

Since FDA approval of the ICD in 1985, the number of implants has grown to over 14,000 worldwide (14). The device has been shown to effectively terminate malignant ventricular arrhythmias and improve patient survival from sudden cardiac death. Furthermore, the use of antiarrhythmic medications has been associated with disappointing results in patients with malignant ventricular arrhythmias and poor left ventricular function (15). Consequently, the use of device therapy in this patient population has been more frequent.

As noted in this report, a variety of operative approaches are utilized for ICD system implant. Some of the patients had a median sternotomy procedure due to concomitant coronary bypass graft surgery. A left lateral thoracotomy was utilized in two patients because of previous coronary bypass surgery while a bilateral anterior thoracotomy procedure was used in one patient due to the history of previous open-heart surgery with subsequent sternal infection. Three patients having no prior history of open-heart surgery had ICD implant by a subxyphoid approach. All operative approaches were tolerated well and were not associated with significant operative morbidity or mortality.

Four patients had permanent pacemakers implanted in addition to their ICD implants. Special concern is warranted in these patients due to the possibility of ICD-pacemaker interaction. The ICD may sense a pacemaker stimulus (atrial, ventricular or both) and the paced QRS complex with resultant double or triple counting of the actual heartrate (16). An inappropriate ICD discharge will result. Double counting may also result from very wide-rate sensing electrograms which may be related to antiarrhythmic medications, placing the rate-sensing electrodes too far apart, or from placement of the electrodes on infarct damaged myocardium. The occurence of double counting in one of the patients was thought to be related to prolonged myocardial electrical conduction due to amiodarone and infarct damaged myocardium. Epimyocardial mapping with repositioning of the rate-sensing electrodes eliminated the double counting.

The problem of an elevated DFT (>20J) was also confronted. This problem may arise from antiarrhythmic drugs, large myocardial muscle mass, insufficient shock energy or suboptimally directed current during shock delivery. These problems may be surmounted by discontinuation of antiarrhythmic drugs, using large defibrillating electrodes, higher energy pulse generators or changing the direction of current flow. The problem of elevated DFTs was managed in one of the patients by discontinuation of amiodarone and use of a triple-electrode configuration allowing for depolarization of a greater myocardial mass.

Of the 26 patients undergoing ICD implant, 11 have had ICD discharges. Although documentation of the patients cardiac rhythm at the time of the discharge is impossible with the present device, the associated symptoms (near syncope, syncope, palpitations, etc.) were highly suggestive of the appropriateness of the discharges.

In the evaluation of ICD discharges in 100 patients, Kelly and his colleagues reported that an easily inducible sustained-ventricular arrhythmia at EPS was found to be predictive of the occurrence of an ICD discharge. In our group of patients, those having an ICD discharge had a greater tendency towards having an inducible VT. Comparison of the number of extrastimuli required to induce the arrhythmia at EPS may have revealed a more significant difference between those patients having and those not having ICD discharges.

Device therapy for malignant ventricular arrhythmias also includes the use of antitachycardia pacemakers. This form of therapy is attractive as it may decrease the number of ICD discharges. Moreover, patients usually do not feel the pacemaker terminating the VT and it is therefore a much more desirable form of therapy. This type of pacemaker, when used for VT management, is usually implanted with an ICD as "back-up" therapy. The possibility of the pacemaker accelerating the VT or inducing VF makes antitachycardia pacemaker implantation alone an endeavor reserved for special circumstances.

Conclusion

Thus far, 26 patients have undergone ICD implantation at CAMC including two patients having pulse generator replacements. Our experience has included a variety of operative approaches, concomitant procedures including coronary bypass grafting, operative mapping with endocardial resection and cryoablation, as well as permanent pacemaker implantation. No significant complications or operative mortality occurred. One death (3 percent) due to heart failure occurred during follow-up. This compares favorably with a reported total cardiac death rate of 7 percent for a year in a series of 270 patients with ICDs (7).

Future ICDs will incorporate antitachycardia and bradycardia pacing, the ability to record electrograms for verification of the appropriateness of discharges and tiered therapy. In this latter feature, arrhythmia treatments will start with the least aggressive approach such as with a pacing algorithm or a very low energy discharge and progress to more aggressive treatments as needed. Implantation of the ICD system without thoracotomy has been tested recently and has been found to be feasible and functional on an acute to intermediate follow-up basis (17). Finally the issue of prophylactic ICD implantation will be addressed in prospective studies as the CABG patch, MUSTT, and MADIT trials (18).

Since this article was written, six additional patients have been implanted with an ICD, which now brings the total count to 32.

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Hepatocellular Carcinoma: A Review of 30 Years Experience

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Abstract

The clinical characteristics of 51 patients with hepatocellular carcinoma over a 30-year period were reviewed. Presenting symptoms commonly included abdominal pain (47 percent), anorexia (41 percent), and ascites (22 percent); however, the ability to make an early diagnosis was complicated by a variety of unusual symptoms accounting for 23 percent of presentations. While cirrhosis (41 percent) was a common associated finding, most patients (92 percent) had no prior diagnosis of liver disease. Histologic diagnosis was made by blind percutaneous biopsy (three performed, 100 percent positive), needle aspiration biopsy (four performed, 100 percent positive), laparotomy (26 percent, 85 percent positive), or autopsy (20). Only six of 51 patients underwent surgical resection.

The overall median survival of 4.1 months and seven percent two-year survival in our series illustrates that thus far medical treatment is not helpful in prolonging life. Attempts to elucidate more effective systemic and regional therapy for established cases of hepatocellular carcinoma and attempts to reduce the incidence of the disease in high-risk populations through the use of hepatitis B vaccine are therefore advised.

Introduction

Hepatocellular carcinoma is one of the most common malignancies in Asian and African populations and may well represent, worldwide, the most common cancer in man (1). Hepatocellular carcinoma occurs less frequently in Western populations; nevertheless, approximately 12,000 cases occur annually in the United States (2 percent of all U.S. malignancies) (2).

We present the Charleston Area Medical Center (CAMC) experience with 51 patients with primary hepatocellular carcinoma treated over a 30-year period.

Materials and Methods

From 1957 to 1988, 51 patients with histologically confirmed hepatocellular carcinoma were seen. Information was obtained from tumor registry records and inpatient and outpatient charts. From these cases, a common data base was constructed which included the following information: sex, race, age, clinical stage, liver function studies, sites of metastases, presenting symptoms, physical findings, alpha-fetoprotein determination, technetium sulfur colloid scan, computed tomography (CT) of the abdomen, abdominal ultrasound, angiography, paraneoplastic manifestations, diagnostic approach (e.g. percutaneous blind biopsy, needle aspiration cytology, or laparotomy with open biopsy), presence or absence of cirrhosis, categories of treatment and survival.

Survival was calculated from the date of hospital admission which preceded autopsy for patients diagnosed postmortem, and from the date of diagnosis in patients diagnosed before death.

Results

The racial distribution of patients was 49 Caucasian patients, one black, and one Oriental. Thirty-six patients were men (70 percent) and the median age was 67 years. Two patients were younger than 45 years and 15 were older than age 75. A history of alcohol abuse was obtained from 31 percent of patients.

The clinical presentation is outlined in Table 1. The most common presenting symptoms included right upper quadrant or epigastric pain, weight loss, anorexia and nausea/vomiting. Unusual presentations included the following: upper gastrointestinal bleeding and portal hypertension in five patients; respiratory failure and dyspnea secondary to pulmonary metastases in five; and an acute abdominal crisis associated with intraperitoneal bleeding secondary to hepatic rupture in two. None of the patients were asymptomatic at presentation.

Paraneoplastic manifestations at presentation were uncommon and included the following: fever above 101°F in two patients; hypercalcemia in two; hypoglycemia in two; and erythrocytosis in one.

Common presenting signs included hepatomegaly in 37 cases (72.5 percent), abdominal swelling or ascites in 23 (55 percent), and jaundice in 18 (35 patient). Evidence for metastatic disease at presentation was seen in eight cases, most commonly in the lungs and bones.

Presenting laboratory values are outlined in Table 2. All patients had some abnormality of liver function tests. No one pattern of liver function abnormality was consistently seen. The prothrombin time was abnormal in 46 percent of patients in whom it was tested. Anemia with a hemoglobin less than 12 gm/dl was seen in 49 percent of patients.

Table 1
Presenting Symptoms in Patients with Primary Hepatocellular Carcinoma

Symptom	*Patients With Symptom (%)*
Abdominal Pain	47
Weight Loss/Anorexia	41
Jaundice	22
Ascites	22
Nausea/Vomiting	22
Abdominal Mass	20
Gastrointestinal Bleeding	10
Respiratory Failure/Dyspnea	10
Acute Abdominal Crisis	4
Fever	4
Bone Pain	2

Table 2
Presenting Laboratory Results in Patients with Primary Hepatocellular Carcinoma

Test	Number Tested	% Abnormal or Positive
Liver Function Test		
Alkaline Phosphates	51	54
Bilirubin	51	46
SGOT	51	54
Prothrombin Time	37	46
Any Abnormal Liver Functions Test	51	100
Anemia (Hct <36%)	49	49
HBsAg Positivity	7	42
Alpha-fetoprotein	20	55
(>1000 ng/ml)		27
(>20 ng/ml)		73
Carcinoembryonic Antigen (CEA)	11	45

Table 3
Histologic Sampling of Hepatic Tissue at Biopsy

	Blind Percutaneous Liver Biopsy	Needle Biopsy (Cytology or Peritonoscopy)	Laparotomy With Open Liver Biopsy
Number of Patients Tested	3	4	27
Positive Histology Obtained	3	4	24
Major Bleeding Complications	0	0	5

The serum alpha-fetoprotein was performed by radioimmunoassay in 20 cases and was greater than 20 ng/ml in seven and greater than 1000 ng/ml in three. The presence of hepatitis-B surface antigen (HBsAg) was evaluated in seven patients and found to be positive in three. Elevation of the serum carcinoembryonic antigen (CEA) was seen in five of 11 patients in whom it was tested, but only one had a serum level above 15 ng/dl.

A liver scan using technetium sulfur colloid was performed in 17 cases and was normal in only three. Abnormalities included an isolated filling defect (eight cases), multiple filling defects (five cases), and a diffuse abnormality without filling defect (one case). An abdominal ultrasound was performed in 11 patients and was abnormal in six. An abdominal CT scan was positive in all 15 cases evaluated. Hepatic angiography was abnormal in all four patients in whom it was performed.

The histologic diagnosis was confirmed by either percutaneous blind liver biopsy, needle aspiration cytology, or laparotomy and open liver biopsy (Table 3). Of the three patients who had a percutaneous blind biopsy and the four who had a needle aspiration cytology, hepatocellular carcinoma was confirmed in all cases. In the 26 cases in which laparotomy and open biopsy were performed, this diagnosis was also confirmed in 24. Five cases of post biopsy bleeding requiring transfusion were encountered, all of which were associated with laparotomy and open biopsy. Ascitic fluid was obtained from four patients and was non-diagnostic in each.

The diagnosis was confirmed only at autopsy in 20 patients. Antemortem attempts at histologic diagnosis were performed in only six of these patients because the remaining were too ill for any invasive diagnostic procedure.

Pathologic examination of hepatic tissue revealed cirrhosis in 21 (41 percent) of the patients. In this series, none of the patients had a pathologic diagnosis of fibrolamellar type of hepatocellular carcinoma.

Of the 51 patients, only six were found to be suitable candidates for surgical resection. Besides surgical resection, other treatment modalities included systemic chemotherapy in nine patients, radiation therapy in three, and intra-arterial chemotherapy in one. Treatment was given on investigational protocols in three patients. Palliative care alone was provided to 32 patients.

The median survival of all patients was 4.1 months (range 1-39 months). The overall median survival of the 31 patients diagnosed antemortem was 5.8 months. In addition, only six survived more than one year, four of whom survived more than 2 years.

Discussion

The clinical features of our cases was similar to those of other studies (3,4,5,6,7). Abdominal pain, an abdominal mass, anorexia and weight loss were the most common signs or symptoms at presentation. Paraneoplastic manifestations of this disease as in other series were uncommon (7 of 51 patients). Some abnormality of the liver function tests was found in all patients.

A problem complicating early clinical recognition of primary hepatocellular carcinoma is that presentations considered unusual can constitute up to 25 percent of cases when a large series is analyzed (8,9,10). Such presentations include: pulmonary nodules and pulmonary insufficiency (10,11); acute abdominal crisis associated with hypotension (11,12); gastrointestinal bleeding (8,11); and fever of unknown origin (8,11). All such presentations were seen in this series. Pathologic evidence of concurrent cirrhosis was seen in 21 (41.2 percent) of the patients did not present as deterioration of a known cirrhotic condition, since all but four patients had no prior diagnosis of liver disease at the time

of presentation. Thus the "classic" case of a known cirrhotic patient experiencing deterioration was a rare presentation in this series.

The majority of patients in other studies have been positive for HBsAg and alpha-fetoprotein (13,14,15,16,17). However, in 10 of the patients in whom it was tested, alpha-fetoprotein was normal and HBsAg was negative in four of seven patients in whom it was tested. Elevation in CEA was also initially present in five of the 11 patients tested, however, only one had a CEA level greater than 15 mg/dl at diagnosis. Since a moderate elevation of CEA levels can occur in decompensated cirrhosis (18,19) without the presence of tumor, CEA levels are not useful in the diagnosis of hepatocellular carcinoma. After diagnosis and if initially elevated, both alpha-fetoprotein and CEA values have been used to monitor the progression of the disease or response to therapy (16,20,21).

The difficulty in making a diagnosis of hepatocellular carcinoma has received emphasis in the past. In this series, the diagnosis was made only at autopsy in 20 cases. A premortem diagnosis was attempted in only six of these cases. In three of these cases, an open-liver biopsy was performed and the histologic diagnosis was negative for malignancy in all three. In a fourth, a biopsy of a rib lesion was read as metastatic mucin-producing adenocarcinoma, probable lung primary. A right cervical lymph-node biopsy in a fifth patient was initially interpreted as pancreatic carcinoma. In a sixth, a needle aspiration of the liver was interpreted as a large-cell lymphoma. In the remaining 14 patients, the premortem presumptive diagnosis was hepatoma in six, cirrhosis in four, metastatic liver disease in three, and thrombophlebitis in one.

A small percentage of patients in this series were detected at a stage amenable to surgical resection. However, the 11 percent resectability rate and two-year survival of seven percent in this series is comparable to other published reports (22,23,24,25,26,27). Thus, after the clinical presentation of symptoms, the aggressive use of currently available diagnostic techniques only rarely results in long-term survival for patients with hepatocellular carcinoma. The seven percent two-year survival underscores the non-surgical nature of this disease in most cases. Unfortunately, non-surgical therapies have not improved these results. Current methods available for improving survival, therefore, include the following:

1) more effective screening for detection of the tumor at an earlier stage,
2) the identification of effective chemotherapeutic agents which is currently being attempted through multicenter trials, and
3) the elimination of known etiologic causes of hepatocellular carcinoma such as hepatitis B through accessible and affordable vaccination programs.

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Extramedullary Plasmacytoma of the Soft Palate

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Abstract

A 59-year-old white male presented with symptoms of an upper respiratory infection and the sensation of nasal fullness or obstruction. There were no constitutional symptoms or history of previous oropharyngeal neoplasms.

Examination revealed a fleshy tan-pink 2 cm. x 1 cm. pedunculated lesion at the base of the uvula posteriorly, extending into the posterior soft palate. Indirect laryngoscopy confirmed extension of the lesion base onto the posterior soft palate. There was no palpable cervical adenopathy. CT scan of the sinuses and neck revealed no abnormality except the soft tissue mass in the area of the uvula and soft palate. Excisional biopsy of the lesion revealed a plasmacytoma which produced a monoclonal lambda chain immunoglobulin. Hemoglobin was 17.2 g/d. Serum electrophoresis and immunophoresis, Bence-Jones protein, bone marrow, and bone scan were normal.

Twenty-six months later, a 1.5 cm. pedunculated lesion was noted at the site of original tumor, which was demonstrated to be recurrent plasmacytoma on excisional biopsy (Figure 1). No other lesions were identified on direct laryngoscopy and skeletal survey was normal. Repeat laboratory studies were normal except for a slight hypergammaglobulinemia (total protein 6.4 g/d., albumin 51.5 percent, alpha 1 globulin 4.0 percent, alpha 2 globulin 11.4 percent, beta globulin 12.8 percent, and gamma globulin 20.2 percent). The patient refused further treatment and has had no further recurrences at one year.

Points in Pathology

Plasma cell tumors were described originally in 1846 by Darymple and Bence-Jones as a disease characterized by proteinuria and bone pain (1). Detailed study of these tumors has allowed distinction of three forms of this disease, each with its own characteristics. The most common of these is multiple myeloma (MM), a systemic disease with localized bone or soft tissue lesions. Much less common are solitary plasmacytoma of bone (SPB) and extramedullary plasmacytoma (EMP). Rather than simply representing stages in a spectrum of plasma of plasma cell tumors, Wiltshaw described distinct differences in biologic behavior between SPB and EMP that support the idea that they are separate entities. She reports that SPB may, however, represent an early stage of MM since characteristics of spread and prognosis in SPB are similar to MM (2). Criteria for diagnosis of the three types are included in her work as well as in other reports (2-5).

As their name implies, extramedullary plasmacytomas are tumors which arise in soft tissues rather than in the bone marrow. EMPs are found in the nasopharynx, paranasal sinuses and upper respiratory tract in the majority of cases (>65 percent). However, they represent only 0.4 percent of malignancies in these areas (3,6-15). Other sites reported include oropharynx, tongue, salivary glands, larynx, trachea, epiglottis, lungs, spleen, tonsils, lymph nodes, gastrointestinal tract, skin and subcutaneous tissues, thyroid, testicle, parotid and breast (3,6-18).

Plasma cell tumors as a group, including MM, are rare, with an overall incidence of 3 per 100,000 per year (1). EMP is estimated to account for less than 10 percent of these (8). The disease most commonly affects males in a ratio of 2:1 with the age of onset between 40 and 70 years (2,3,8-11,19). Presenting complaints are usually pain, epistaxis and obstruction when the upper respiratory tract is the site of origin (2,9-15). Workup of patients with suspected plasma cell tumors should include urine for Bence-Jones protein, serum protein electrophoresis, serum immunoelectrophoresis, bone marrow examination, radiological skeletal survey, complete blood count, and erythrocyte sedimentation rate.

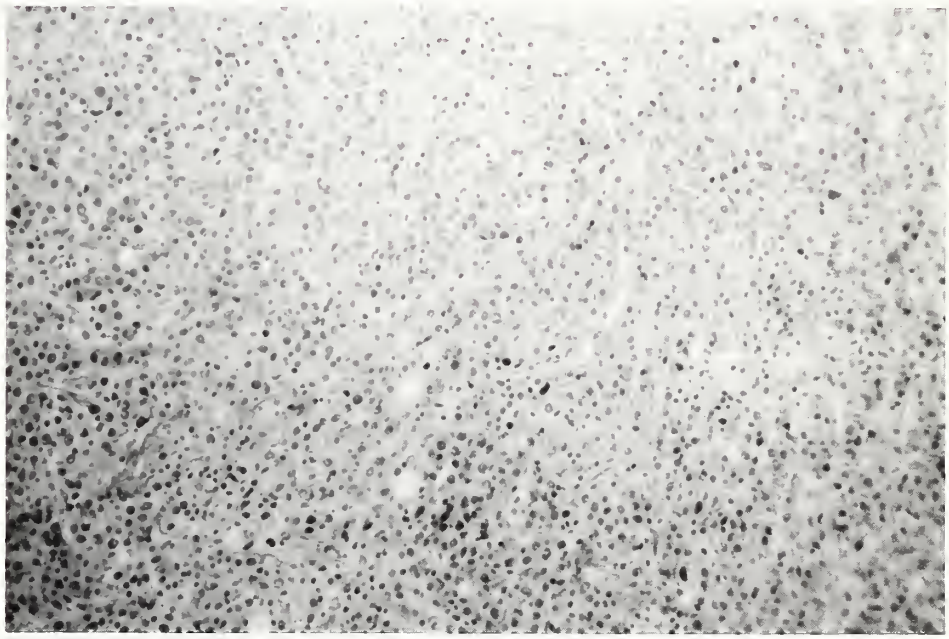

Figure 1. (H & E 20X) Photomicrograph showing sheets of cells with rounded hyperchromatic nuclei. The cytoplasm is abundant, eosinophilic and slightly granular. A few lymphocytes are present between plasma cells.

Criteria for diagnosing EMP include a biopsy-proven isolated plasmacytoma with no other signs of systemic disease (3,4). The histologic characteristics of plasmacytomas have been reviewed by Batskis and are distinguished from plasma cell granulomas, which are sometimes confused with plasmacytomas (5). The granulomas are reactive inflammatory lesions with normal plasma cells surrounded by connective tissue while plasmacytomas consist of monocellular sheets of plasma cells with litte surrounding matrix. There may be nuclear and cellular atypia with mitotic figures. Russell bodies may be present in both. These histologic findings are supported by Meir and colleagues who elaborate on immunohistochemical aspects of EMP and SBP, with emphasis on predicting likelihood for progression to MM (19).

Monotypic staining for kappa or lambda light chains supports a diagnosis of plasmacytoma rather than plasma cell granuloma. The presence of immature nuclei characterized by prominent nucleoli was found to be predictive of progression of plasmacytoma to MM.

Staging of EMPs is based on spread of the disease. Stage 1 involves only local controllable disease. Stage 2 involves tumors with local extensions with or without local nodal involvement. Stage 3 involves cases with distant metastasis (5). Plasmacytomas are quite radiosensitive. Following biopsy for tissue diagnosis only and exclusion of evidence of MM, radiation therapy is recommended as the mode of treatment with a total dose of 4,000 to 6,000 rads directed at the tumor site in fractions of 175 to 200 rads. The treatment ports may include the regional lymph nodes if there is suspected local spread (7,9-11). Local recurrence after radiation therapy is reported to occur in 0-31.5 percent and usually occurs in the first five years after treatment, but may occur many years later (2,3,9-11). Dissemination of disease may be represented by either MM or multiple soft tissue or bone metastasis in areas not typically associated with MM (7). Reported rates of dissemination vary from 6 percent-35 percent (2,3,9,19), EMP local recurrence or disseminated disease can be often treated with chemotherapy with good response (2,3,9-11). The overall five-year survival rate for EMP is nearly 100 percent, while 50 percent of patients with MM will die within two years of diagnosis (3,11,18).

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Use double spacing throughout, including (in the following order) title page, abstract, text, acknowledgements, references, tables, and legends for illustrations. Begin each of the following sections on separate pages: title page, abstract, text, acknowledgements, references, individual tables, and legends for illustrations. Number pages consecutively, beginning with the title page. Type the page number in the upper right-hand corner of each page.

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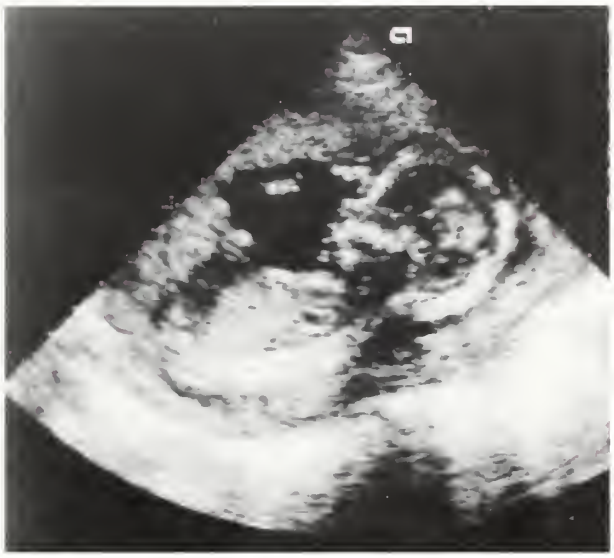

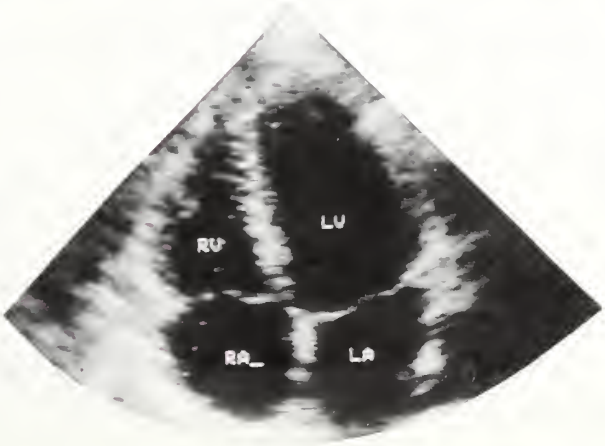

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President's Page

Constantino Y. Amores M.D.

Trustworthy, Caring Professionals

Long before many of us even thought of going into the medical profession, we were probably told by our friends and families that "he should be a doctor" or "she would make a good doctor." From an early age, our actions had hopefully reflected a caring attitude that made others feel we might be worthy of having the revered title of P H Y S I C I A N someday.

After making the decision to actually study medicine, we were given countless hours of textbook instruction and anxiously awaited the day we would be able to put all our knowledge to use. We could hardly contain the joy we felt when we were able to finally care for our first patients.

Woe, to those physicians who went into this wonderful profession for other reasons. Individually, we should personify the image of a trustworthy, caring person whose only intention is to help alleviate pain and sufferering.

Today, as never before so intensely, the integrity of our profession is shaken, the purpose of our being is questioned, and the battle cry against us is M O N E Y.

As medical professionals, we are at a major disadvantage because we are not trained and neither do we have the temperament to fight this kind of attack. Our adversaries have managed to print G R E E D on our forehead and it is up to us to erase it.

This is not the first time that M O N E Y has been an issue in the history of American medicine. In the late 19th century, the young American Medical Association was almost completely decimated in the struggle against the homeopaths, the individuals who believed in treating diseases with drugs which are capable of producing in healthy persons symptoms like those of the disease to be treated.

With influential individuals like Dr. Oliver Wendall Holmes on their side, the large number of homeopaths and self-proclaimed medicine men were able to severely shake the integrity of the AMA. The issue was M O N E Y and the doctors of that era survived because they were able to show that their medical practices were the better way to treat illnesses than those of the homeopaths and medicine men. We should be able to prove this point even more effectively in the 1990s with all of the technology science has to offer, but unfortunately it seems as though our image as trustworthy, caring professionals whose only goal in life is to help our patients, has been tarnished.

It is very important today that we do everything in our power to regain the respect of our patients, not only for ourselves but for the medical profession as well. We must show patients at all times that they are our number one priority by treating them as we would want to be treated—with courtesy, individualized attention and regard for privacy. In addition, it is a imparitive that physicians offer solutions to the problems dramatically affecting West Virginias such as the cost of medical care, access to quality medical care and poor health habits.

To help lessen the ever-increasing costs of medical care, physicians need to strengthen continuing medical education requirements for WVSMA membership so physicians will have the most up-to-date knowledge of the best technologies and cost-effective treatments for patients. Pre-admission and utilization standards must be encouraged and a strong peer review system established to further defer the costs of medical care. WVSMA physicians should initiate the process of sanctions and disciplinary measures for members who do not measure up to proper standards of practice.

To insure access of quality medical care, physicians need to treat all patients regardless of creed, color or financial status. Secondly, doctors must work to see that the special recommendations given in the WVSMA's report on indigent care be adapted by the Legislature and strive to make West Virginia a more desirable place in which to practice medicine so more doctors will remain and relocate in the state. In addition, an outstanding medical education system and the best possible hospital system must be supported and maintained.

Wellness is critical in the state because many factors such as obesity and tobacco usage are contributing to poor health. WVSMA members should actively support the Healthy West Virginia Coalition which is striving to increase and coordinate wellness programs.

In summary, physicians must use all available strengths and influences to fight for the integrity of the medical profession. Of all the steps that must be taken though, first and foremost is putting more C A R E into each of our practices.

—Constantino Y. Amores, M.D.

AIDS Phobia?

"Hey, Hey, Ho, Ho, AIDS Phobia Has Got To Go." There go the marchers down the street with their freshly painted signs bobbing on sticks above their heads.

Their message — the great menace is not AIDS itself, but the *fear* of AIDS — Reminds one of Franklin Roosevelt's message in 1932, "We have nothing to fear but fear itself." More akin, however, to the story of a Madison Avenue solution to the cancer problem during the heyday of the advertising industry — "Cancer is good for you."

Sadly, AMA spokesmen are quoted to the effect that there is no need to require testing of medical personnel for the AIDS virus because the risk of contracting AIDS from a doctor or nurse is miniscule. The "tremendous cost" of such testing is cited as a good reason for opposing such an AIDS testing effort.

We're not in the habit of disputing AMA positions or pronouncements, but neither are we party-liners. It's a bad position for the AMA. We are physicians, not social workers. We deal with disease, not politics.

Why should we fear saying the politically incorrect thing about AIDS? We have been doing similar things for decades. Let's worry more about disease in the gay community rather than about the dainty sensibilities of members of that group over the possibility of being identified as AIDS virus carriers.

If a doctor is in any type of practice wherein he might, in any conceivable way, unintentionally transmit AIDS or any other lethal disease to a patient, those at risk need to know about that risk. Statistics have shown that the incidence of positive testing to the AIDS virus is higher among medical personnel than among other occupational groups. It is suspected that a reason for this is the extraordinarily high possibility that medical personnel might unknowingly be infected by contaminated blood from patients with undiagnosed and unsuspected AIDS virus. Estimates of the number of AIDS virus carriers vary somewhat, but the best estimates of the correct number is something short of two million carriers out there. Most of these do not know the grim fact that they are infected with the AIDS virus.

Patients without AIDS have reasonable cause to fear contracting that dread disease from a source over which they have no opportunity to control the possibility of contracting the AIDS virus. They need reassurance. We have the capability of giving them that reassurance by testing ourselves for the AIDS virus.

In giving such reassurance, we then have every right to demand its corollary. Medical personnel need to know which patients have blood contaminated with the AIDS virus. We need routine testing for the AIDS virus on every hospital admission.

Universal precautions? Does anyone even guess what these precautions have already added to the cost of medical care?

No one has ever really suggested that medical personnel anywhere have been careless or slovenly in their handling of blood or any other product of the human body. To suggest that universal precautions would add very little to precautions already in use, states only the obvious. For someone to suggest that universal precautions can be consistently applied in every hospital, clinic and doctor's office is wishful thinking. To suggest that universal precautions can be cost effective or perhaps even effective in any discernible way, is foolishness.

Who gives a damn about how someone may have contracted AIDS? If the Public Health Service wants to do contact tracing, that is its affair. AIDS is not the first disease that victims have tried to hide, but it is the only disease that anyone has ever attempted to politicize. It needs to be treated like any other disease.

The problem is not AIDS phobia. Fear of AIDS is well founded. The biggest problem in dealing with AIDS is the attempt to mask awareness of its presence in the community by those who, using political pressure on some feckless legislators, have managed so far to accomplish their unworthy aims.

—SDW

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Four scientific sessions and concurrent meetings for physicians and the public will again be featured at the West Virginia State Medical Association's 25th Mid-Winter Clinical Conference, January 24-26, at the Radisson Hotel in Huntington.

This year, the popular session on "Controversies in Medicine" will deal with Cesarean sections vs. vaginal births, as well as the pros and cons of treating cardiac patients with Thrombolitic TPA vs. Streptokinase. The speakers for the Cesarean section panel are Robert P. Pulliam, M.D., an OB/GYN in Beckley, who is the president-elect of the WVSMA, and Howard R. Gordon, M.D., professor and chairman of the Department of OB/GYN at West Virginia University, Charleston Division. Dr. Pulliam's talk is "The Pendulum Swings: 'From Once a Section, Always a Section' to 'A Vaginal Birth for Everyone - Where Will It Stop?'" After Dr. Pulliam's lecture, Dr. Gordon will make his presentation entitled "Are There Too Many Cesarean Sections?"

An early registration form for the Mid-Winter Clinical Conference is printed on page 411 and more details about the meeting may be obtained by contacting Nancie Divvens at 925-0342.

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Gordon

Panelists Highlighted

Dr. Pulliam is a native of Beckley who earned a B.S. degree at Davidson College in Davidson, N.C., and then obtained both his M.S. degree in biochemistry and his M.D. degree from the Bowman Gray School of Medicine in Winston-Salem, N.C. He completed his internship at University Hospital in Seattle and did residencies at The Sloan Hospital for Women and Columbia Presbyterian Medical Center in New York City.

A lieutenant commander in the U.S.N.R., Dr. Pulliam served in Newport, R.I., from 1966-68. Following his military service, Dr. Pulliam returned to Beckley to open his OB/GYN practice and joined the staffs of Raleigh General Hospital, Beckley Hospital and Beckley Appalachian Regional Hospital.

A clinical professor of obstetrics and gynecology at Marshall University since 1984, Dr. Pulliam is currently enrolled in the MBA program at the College of Graduate Studies in Charleston. He is the co-founder of DOCS, Inc., a computer company for medical offices, and is also the founder and major medical officer in Professional Medical Ultrasonics, Inc., a full-service private ultrasound laboratory.

Before being chosen president-elect of the WVSMA in 1991, Dr. Pulliam served on the WVSMA Council for a year. Active in many other professional organizations, Dr. Pulliam is a past president of the Raleigh County Medical Society and a Fellow of the American College of Obstetricians/Gynecologists. He is also a member of the AMA, the West Virginia Obstetrical/Gynecological Society, the American Fertility Society and the American Association of Gynecologic Laparoscopists.

Dr. Gordon received an A.B. degree from Princeton University in 1957 and then completed a fellowship in microbiology and genetics at the University of Rochester in Rochester, N.Y., where he also obtained his M.D. degree. He remained at the University of Rochester for an internship before relocating to New York City for a residency at Columbia Presbyterian Medical Center.

After his residency, Dr. Gordon joined the teaching staff at Tripler Army Medical Center in Honolulu for three years and then became the director of obstetrics at San Bernardino County Medical Center in San Bernardino, Ca. During this time, Dr. Gordon also taught obstetrics and gynecology at the U.C.L.A. School of Medicine and in 1977 resigned his position at San Bernardino when he was named an associate professor at U.C.L.A.

The following year, Dr. Gordon left to direct the high risk obstetrical program at Alta Bates Hospital in Berkeley and to work as an clinical associate professor at the University of California at San Francisco School of Medicine.

In 1987, Dr. Gordon moved to West Virginia to accept two of his current posts as director of maternal and fetal medicine and director of the obstetric ultrasound department for the Charleston Area Medical Center and WVU, Charleston Division. From 1988-89, Dr. Gordon served as medical director of the Women's Health Center of West Virginia, Inc. in Charleston, and in 1990, was named to his other current role as professor and chairman of obstetrics and gynecology at WVU, Charleston Division.

5th Family Practice/Sports Medicine Weekend Planned

The West Virginia Chapter of the American Academy of Family Physicians 5th Annual Family Practice Weekend and Sports Medicine Conference, November 8-10, will this year focus on otolaryngolic emergencies, headache management, rosacea, nutrition, gynecologic infections, anxiety disorders, stress, sexual disorders and sports medicine.

The Radisson Hotel in Huntington will again be the location for the conference which is sponsored by the Family Medicine Foundation of West Virginia, the Marshall University Department of Family Medicine and Community Health, the Division of Sports Medicine of the Marshall University School of Medicine and Scott Orthopedic Center, Inc.

The meeting is designed to offer topics of interest to family practice physicians, residents, medical students, nurses, physicians' assistants, medical technologists, coaches and trainers. The program is accepted by the AAFP for 16.5 prescribed hours and by the AMA for 16.5 hours in Category I in continuing education. AOA credit towards Category 2-A for 16.5 hours is also approved and individual forms will be located at the registration desk.

Registration begins at 7 a.m. on Friday, November 8, and the first lecture, "The Sports Physical - Maximizing Health Care for the Adolescent Athlete," begins at 8:20 a.m. following the welcome. All of the programs on Friday are devoted to sports medicine and include several speakers from out-of-state such as Dr. Doug McKeag of Michigan State University who will discuss "Primary Care Sports Medicine: An Overview," and Dr. John Brems of the Cleveland Clinic Foundation who will discuss "Shoulder Injuries."

Saturday morning's session is called "ENT Update for the Family Physician," and will focus on six topics. A variety of subjects will then be covered in the afternoon including gynecologic infections, which will be addressed by

Dr. McKeag

Dr. Brems

Dr. Tobin

Drs. Marla Tobin of Warrensburg, Mo., and Martin Weisburg of the Jefferson Medical College at Thomas Jefferson University in Philadelphia.

On Sunday, the Fifth Annual William B. Rossman Symposium will be held featuring three presentations on the subject of "Anxiety In Your Patients." Dr. David Kupfer of the University of Pittsburgh is the moderator for this panel and is also one of the speakers.

Special highlights during the weekend will be a fund-raising party for the Family Medicine Foundation of West Virginia at the Huntington Civic Center at 8 p.m. Saturday. The Drifters will play at this event and former Los Angeles Rams player Denny Harrah will sign autographs. Harrah will also be making a speech at the conference entitled "Drug Free, West Virginia Proud."

For more details, contact the WVAAFP at 776-1178.

AMA Offers Three Teleconferences on Depression in Primary Care

The American Medical Association and the National Institute of Mental Health's Depression, Awareness, Recognition and Treatment Program (D/ART) are sponsoring three teleconferences on Depression in Primary Care to be aired at participating hospitals at no cost to attendees.

The first teleconference, airing on October 24 at 2 p.m., addresses epidemiology, etiology and diagnosis. Three cases will be presented to show different presentations of depressive symptoms which might be seen by primary care physicians.

On November 21, the second program will give information on pharmacological and psychotherapeutic treatments of depression, as well as guidelines for referring patients to mental health specialists.

The final teleconference, which will be presented on December 11, focuses on special populations, including elderly patients and adolescents. This program will address differentiation between depression and normal mood variations and keys for making that distinction.

For content and hospital location information, contact Mary Ayesse, MSW, MPH, or Patrick McGuffin, Ph.D., Department of Mental Health, AMA, 515 N. State Street, Chicago, IL 60610, (312) 464-5066.

Parkersburg Surgeon Acquires State's First Vascular Lesion Laser

Dr. Tarrant

Dr. Lawrence W. Tarrant, Parkersburg plastic and reconstructive surgeon, has opened the first treatment center in West Virginia offering the Candela Vascular Lesion Laser.

This new flashlamp excited dye laser is the world's first laser specifically developed to treat benign vascular lesions like port wine stains, strawberry birthmarks and telangiectasias (facial spider veins). This laser system is a major advance over current methods of treatment because of its precise selectivity and ability to treat patients of all ages, even infants, without damage to normal surrounding tissue and with minimum need for anesthesia. It works through a unique effect to eliminate blood vessels just below the surface of the skin.

Port-wine stains, which occur in 3 out of every 1,000 births, can usually be partially or totally removed with the Candela laser. It can also eliminate facial and leg spider veins, as well as soften and decrease the thickness of scars caused by surgery, suturing or burns.

"These lesions affect from 10 percent - 30 percent of the population," Dr. Tarrant said. "In past treatments, side effects including scarring, often occurred. With the Candela laser, patients will have the advantage of minimal risk of side effects."

According to Dr. Tarrant, this new laser allows physicians to treat birthmarks and facial veins with a resulting 50 percent - 100 percent clearing after several treatments. Treatments last from 5 to 30 minutes and the number of treatments depends on lesion size and depth.

New WVACOS Officers

The leaders of the West Virginia Chapter of the American College of Surgeons were photographed at The Greenbrier during their annual meeting. Pictured are (front row) Drs. Gene Duremdes, councilor; Robert Gustafson, councilor; Donald McDowell, president-elect; Eric Mantz, president; Carl Kite, second vice-president; Amabile Milano, councilor; and Jamal Khan, councilor. (Second row) Drs. James Carrier, councilor; Thomas Chang, past president; Herbert Warden, governor; Roger King, secretary-treasurer; and Paul Burke, councilor.

Seminar to Discuss Chemical Dependency

Alcohol and drug-related problems will be explored at the Chemical Dependency Conference on September 19-21 at the Charleston Civic Center.

Organized by the Charleston Area Medical Center, Charleston Chamber of Commerce, Kanawha Valley Bar Association, Kanawha Medical Society, West Virginia University Health Sciences Center/Charleston Division and United Way of Charleston, the conference is designed to present current information about the extent of chemical dependency in the nation as well as West Virginia. Prevention, detection, recovery and treatment options will be discussed by regional and nationally recognized speakers.

CAMC has designated the workshop for nine hours of Category I credit of the Physician's Recognition Award of the AMA. The program has also been reviewed and is acceptable for 10.5 hours of Continuing Legal Education Credit. In addition, the meeting is approved for 10.5 contact hours for nursing education and application has been made for CEUs from WVU for social work continuing education credit.

For more information, call the CAMC Department of Education at 348-9581 or Fran Finley at 348-6202.

Roster Reminder

The WVSMA is compiling all of the data for the new Membership Roster. If you have had a change of address or phone number, or added a fax machine to your practice since you last completed a roster information form, please contact Donna Webb at 925-0342 as soon as possible so your personal data will be correct.

Dr. Chillag Named Interim VP of Health Sciences

Dr. Chillag

Shawn A. Chillag, M.D., has been appointed interim associate vice president for Health Sciences at the Charleston Division of the West Virginia University Health Sciences Center, replacing William O. McMillan Jr. M.D., who has assumed the position of executive director of the Area Health Education Center in Wilmington, N.C.

The one-year appointment became effective August 1, and will allow time for a nationwide search for a permanent replacement. Dr. Chillag, a native of Logan, has been with the Charleston Division since 1988 as chairman of the Department of Internal Medicine. His professional career also includes faculty appointments in internal medicine at WVU in Morgantown and at the University of South Carolina in Columbia, S.C.

Since his arrival at the Charleston Division, Dr. Chillag has received many honors including Clinician of the Year for the past two years and the 1989 Resident Staff Award for Excellence in Teaching.

Allegheny Trek To Benefit ALAWV

The West Virginia Scenic Trails Association will conduct the 11th Annual Allegheny Trek, Saturday, October 12 to Monday, October 14, to raise funds for the educational and research programs of the American Lung Association of West Virginia.

The hike will cover about 26 miles from White's Draft near Sherwood Lake to Beaver Creek Campground at Watoga State Park.

For more information, call ALAWV at 342-6600, or write P.O. Box 3980, Charleston, WV 25339.

New Orleans Site of Primary Care Update

"A Primary Care Update," the Scientific Assembly of Interstate Postgraduate Medical Association, will be held October 28-31, at the Hyatt Regency in New Orleans.

Lectures and group discussions by a faculty of 41 medical educators will highlight key topics in the areas of cardiology, geriatrics, gastroenterology, gynecology, neurology, ophthalmology, endocrinology, infectious diseases, pulmonology and psychiatry. Practical office management for the primary care physician will be emphasized.

IPMA is accredited by the Accreditation Council on Continuing Medical Education to sponsor continuing medical education for physicians. This meeting is eligible for 24 hours of Category I credit of the Physician's Recognition Award of the American Medical Association.

The program has been reviewed and is acceptable for 24 prescribed hours by the American Academy of Family Physicians, and, by reciprocal agreement, for 24 hours study credit by the College of Family Physicians of Canada.

Registration materials are available from IPMA at (608) 257-1401 or P.O. Box 5474, Madison, WI 53705.

Rush-Presbyterian Hepatic Disease Symposium Set

The Second Annual Symposium on Hepatic and Biliary Disease will be held at Rush-Presbyterian-St. Luke's Medical Center in Chicago on November 1.

The day-long discussion and presentation format will focus on current issues in the management and treatment of liver disease. All medical professionals and interested persons are invited to participate. CME credit has been applied for and the registration fee is $150.

To register, call Suzanne Buss, physician relations coordinator for the Rush Liver Transplant Program, at (312) 942-6242.

Software Available for Rural Clinics

Non-profit health care providers in West Virginia can obtain free copies of the Lotus Development Company's Lotus 1-2-3 spreadsheet software under a grant awarded recently to the Office of Health Services Research (OHSR) at the West Virginia University School of Medicine.

The Cambridge, Ma., software firm has agreed to provide up to 124 copies of the program — worth more than $60,000 — to clinics and other public health care facilities around the state.

Mike Furbee of OHSR said the grant will supplement an established program, funded by the William R. Hearst Foundation, which provides computers to rural clinics in West Virginia and establishes a system for exchange of health and financial data. OHSR will provide training to the clinic staff members who will be using the software.

Health care facilities may contact Furbee at 293-2601 for information about the Lotus 1-2-3 program.

OSU to Present Cardiology Update

The latest information on treatment of cardiology patients will be discussed October 4 and 5 at a program in Columbus entitled "Cardiology Update 1991."

This seminar is co-sponsored by University Hospitals, the Center for Continuing Medical Education, the College of Medicine, and the Department of Internal Medicine's Division of Cardiology and will be held at Rhodes Hall Auditorium at the Ohio State University Hospitals.

Sessions will offer instruction in how to assess, manage and intervene in patients with progressive heart failure; how to evaluate and interpret the predictive value of functional versus anatomic cardiovascular tests; and how to improve clinical ECG interpreting skills in an interactive case presentation format.

For more information, contact Ohio State's Center for CME at 1-800-492-4445 or (614) 292-4985.

Hal Wanger Family Medicine Conference Scheduled

The 17th Annual Hal Wanger Family Medicine Conference, which will held at the West Virginia University Health Sciences Center, October 10-12, will examine a broad spectrum of topics of interest to the family practitioner.

The two-and-a-half day program will feature 22 WVU School of Medicine professors and is designed to give participants a better understanding of common and unusual problems encountered in day-to-day practice, the physiology of the bowel and bowel treatment modalities, the immunologic aspects of allergy, treatments for different headaches, and cancer therapy.

Robert M. D'Alessandri, M.D., dean of the WVU School of Medicine, will provide the opening remarks for the conference at 8:55 a.m. on Thursday, October 10 and then John F. Brick, M.D., will discuss "Headaches Are More Than Two Aspirin." The other presentations during the Thursday morning session will be "Newer Immunologic Aspects of Allergy," "Review of Bowel Physiology," and "Inflammatory Bowel Disease."

Following lunch on Thursday, Marian L. Swinker, M.D., M.P.H., will speak on "The Abnormal PAP Smear." Three more presentations, "Pre-Op Evaluation of the Geriatric Patient," "Persistent Resistant Vaginitides," and "Concepts in

Chronic Pain Management" will be featured during the afternoon session.

The first speaker for Friday, L. Phillip Maxwell, M.D., will discuss the subject of "How Innocent Are Those PVSs?" The other Friday presentations will be "A New View of Sinus Disease," "Panic Disorders," "Management of Lung Tumors," "C.P.C. for the Family Physician," "Dementia — How Much of a Work-up!" "The 'Newer' Infectious Diseases," "Sun, Sand and Cholesterol," and "Thrombolytic Therapy for the Acute MI."

Saturday's session begins at 8 a.m. with Arthur I. Jacknowitz, Pharm. D., discussing "Pharmacologic Management of Alzheimer's Disease." At 8:45 a.m., Michael J. Lewis, M.D., Ph.D., will speak on "Fat Kids in West Virginia" and following a break, the conference will proceed at 9:45 a.m. with the lecture "Highlights in Cancer Therapy" by Peter C. Raich, M.D. The meeting will conclude with a lecture by William T. Stauber, Ph.D., on the subject of "Exercise in the Aging Population."

Following the conference, participants are invited to join WVU faculty at the Mountaineer Physicians' tent next to Mountaineer Field before the Temple football game.

The conference is sponsored by the West Virginia Chapter of the American Academy of Family Physicians, West Virginia University School of Medicine, Department of Family Medicine and the Office of Continuing Medical Education. The Office of CME certifies that the seminar meets criteria for 16 credit hours in Category I of the Physician's Recognition Award of the American Medical Association. The meeting also has been approved for 16 prescribed credit hours by the American Academy of Family Physicians, and 1.6 continuing education units. In addition, the Editorial and Advisory Board of the Audio-Digest Foundation, a non-profit subsidiary of the California Medical Association, will be tape recording the event.

John W. Traubert, M.D., associate dean of student affairs at the WVU School of Medicine, is the course coordinator for the conference.

To register, use the form which appears on the following page or use your VISA or MasterCard and call the WVU CME Office at 293-3937 or 1-800-WVA-MARS.

THE MYERS CLINIC — Philippi, West Virginia

Notice: Seeking Internal Medicine, Pediatrics, and/or Family Practice, must be Board Certified or Board Eligible.

Also: Seeking Locum Tenen—Family Practice

Contact: Lonnie L. Crane, 112 North Woods Street, Philippi, WV 26416. 1-(304) 457-2800

Radiology:
Halberto G. Cruz, M. D.

Surgery:
J. W. Woodford, M. D.

Pediatrics:
E. G. Kreider, M. D.

Pathology:
Fulvio Franyutti, M. D.

Internal Medicine:
Karl J. Myers, Jr., M. D.

WEST VIRGINIA UNIVERSITY SCHOOL OF MEDICINE
OFFICE OF CONTINUING MEDICAL EDUCATION

17th Annual Hal Wanger Family Medicine Conference

October 10, 11 & 12, 1991

Registration Form

Registration-Enrollment is recommended by Sept. 15, 1991

Name _____ Specialty _____

Address _____ City _____ State _____ Zip _____ County _____

Daytime Telephone ( ) _____ SS# _____ - _____ - _____

Please specify the exact name you would like printed on your certificate. Print or type name

_____

Course Fees*

	Price	Quanity	Total
Physicians			
Thursday, Friday and Saturday	$165		
☐ Thursday only ☐ Friday only	$125		
Saturday	$ 85		
Other Health Care Professionals			
Thursday, Friday, and Saturday	$ 85		
☐ Thursday only ☐ Friday only	$ 65		
Saturday	$ 45		
WVU Faculty, Residents, and Students** *Please check days you plan to attend* ☐ Thursday only ☐ Friday only ☐ Saturday only ***Advance registration is required*	no charge		
Football Tickets (limit 4) WVU vs. Temple(Parents Weekend)	$ 17		
# of guests attending "Mountaineer Physicians" Tailgate Tent	no charge		
		Total	

**Course fees include conference materials, meals and Saturday parking.*

Credit Card payment: Please charge my ☐ Visa ☐ MasterCard Please include card number _____

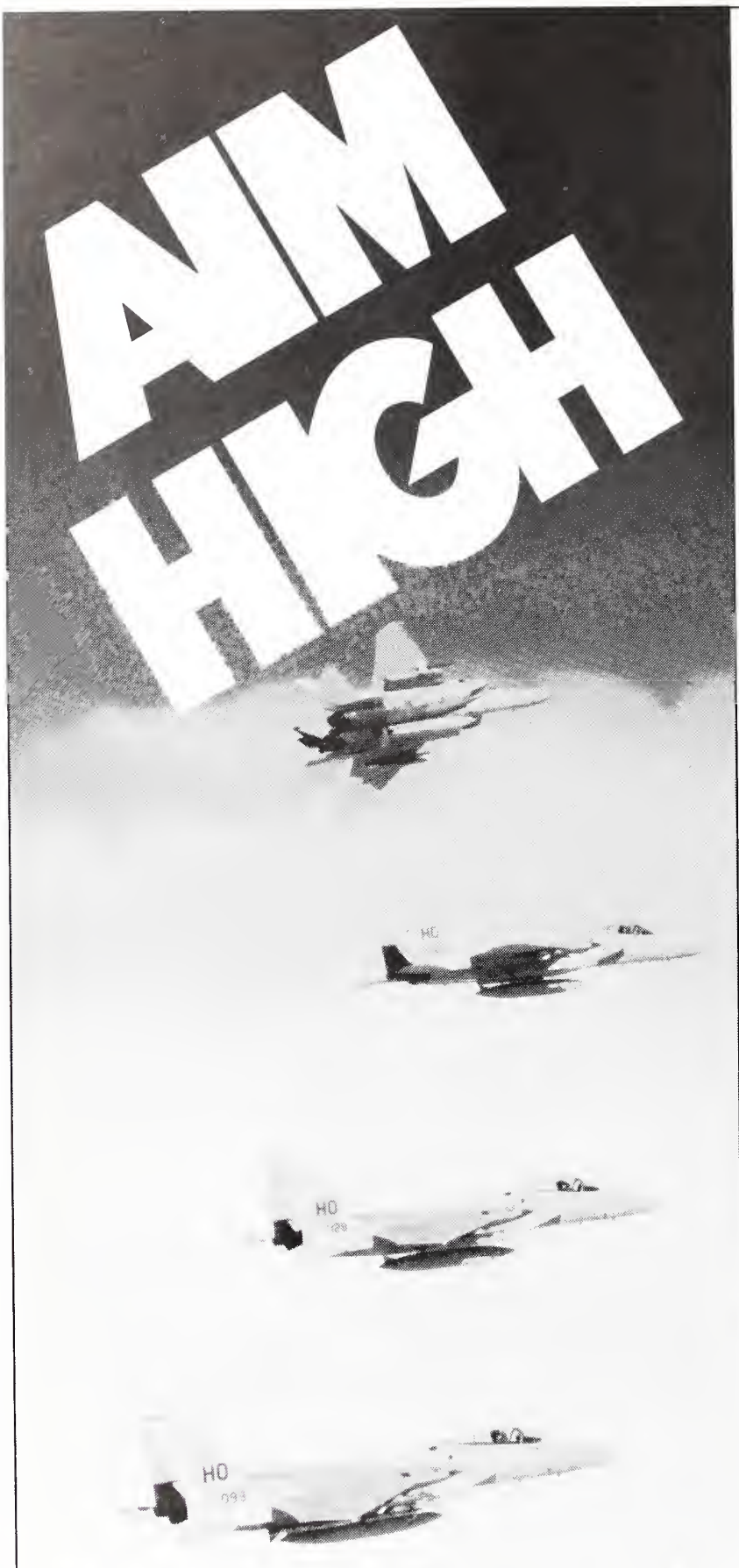
Expiration Date _____ Authorization Signature _____

Make check payable to *WVU Foundation* and return with this form to *Office of Continuing Medical Education*, Division of Physician Services, 1244 Health Sciences South, West Virginia University, Morgantown, WV 26506

Special Requirements

If you require access and parking for the handicapped, please so indicate:

_____



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Continuing Education

Listed on this page are some of the upcoming continuing education programs which will be held throughout the state.

The programs this month were compiled by the following individuals: Robin Rector, coordinator of CME for Charleston Area Medical Center; Cynthia Kemp, WVU conference planner; David Bailey, MU director of CME; Marie Chute, secretary of the Ohio Valley Medical Center CME Department; and Thelma Wilson, education coordinator of the Raleigh County Medical Society.

These programs are tentative and subject to change. Further details about these CME activities may be obtained by calling Rector at 348-9580; Kemp at 293-3937; Bailey at 696-7018; Chute at 234-8310; and Wilson at 255-6341. Other national and state meetings are listed in the Medical Meetings Section of the *Journal.*

This schedule is presented as a convenience for physicians. If you would like to have the continuing education programs offered by your institution or association published in the *Journal,* please contact Nancy Hill, managing editor, at 925-0342.

CAMC/WVU Health Sciences Center - Charleston

Sept. 14 - "Basic Statistics," WVU Health Sciences Center Auditorium 8:30 a.m. - 12:30 p.m.

Sept. 19-21 - "Chemical Dependency Conference," Charleston Civic Center

Sept. 23 - "Oncology Teleconference," Room 2000, WVU Health Sciences Center, 12:30 p.m. - 1:30 p.m.

Sept. 28-28 - "Trauma Seminar," Charleston Marriott

WVU Health Sciences Center - Morgantown

Sept. 13-14 - "Surgery Update, 1991," WV Chapter of American College of Surgeons Conference

Sept. 14 - "Geriatrics: Senior Care 1991"

Sept. 22-23 - "Rural Health Conference - Choices and Challenges for West Virginia"

Sept. 26-28 - "2nd Annual Hearing Impaired Conference"

Oct. 5 - "Practical Neuropsychiatry"

MU School of Medicine - Huntington

Sept. 21 - "Quality Direction in Long Term Care," Holiday Inn-Gateway

Sept. 27 - "Annual Cancer Conference," Radisson

Oct. 4-5 - "Rowland Burns Endowment Lecture - Cardiology Update

Ohio Valley Medical Center - Wheeling

Sept. 25 - "Controlling Ventricular Dilation in the Compromised Myocardium," James Goldstein, M.D., FACC, assistant professor of Medicine and Cardiology, Washington University School of Medicine, 8 a.m.

Raleigh County Medical Society-Beckley

Sept. 17 - "Common Infections in the Elderly Patient," James S. Tan, M.D., Black Knight Country Club, 6:30 p.m.

Sept. 19 - "WV Board of Medicine - Update on Past Accomplishments and Future Directions," Eileen Catterson, M.D., Black Knight Country Club, 6:30 p.m.

Sept. 24 - "Sleep Disorders: Their Diagnosis and Treatment," George Zaldivar, M.D., Black Knight Country Club, 6:30 p.m.

Sept. 26 - "Stress and Anxiety in Women and PMS," Ivan Backerman, M.D. Black Knight Country Club, 6:30 p.m.

Sept. 28 - "AIDS: 1991 Update," Charles Schleupner, M.D., Elizabeth Funk, M.D., Susan Beekman, BSN, MPH, Annette Jennings, MA, Veterans Administration Medical Center, 9:15 a.m.

Outreach Programs

Key to Sponsors

★ WVU Health Sciences Center, Morgantown

☐ CAMC/WVU Health Sciences Center-Charleston

(Check locally for more details)

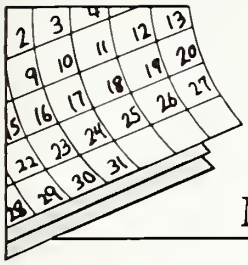
Man ☐ Man Appalachian Regional Hospital, September 17, 7 p.m., "Swallowing Disorders," Peter Americo, M.D.

Ripley ☐ Jackson General Hospital, September 13, noon, "Trauma Update," Robert Wallace, RN.

Spencer ☐ Roane General Hospital, September 17, 12:30 p.m., "Thrombolytic Therapies," Judy Chamberlain, RN.

Point Pleasant ☐ Pleasant Valley Hospital, September 26, noon, "Board of Medicine Update," Ronald Walton, executive director of WV Board of Medicine

South Williamson ☐ South Williamson Appalachian Regional Hospital, September 26, 5:30 p.m., "Medical and Legal Issues," Paula Branfass, CAMC general counsel



Medical Meetings

September

19-21—Chemical Dependency Conference, CAMC, Kanawha Medical Society and other Kanawha Valley Sponsors, Charleston.

22-27—American Society of Maxillofacial Surgeons, Seattle.

22-27—Weeklong MRI Fellowship, Magnetic Resonance Imaging Education Foundation Inc., Cincinnati.

23-24—5th NIMH International Research Conference: The Classification, Recognition and Treatment of Mental Disorders in General Medical Settings, Washington, D.C.

23-25—15th National Conference on Correctional Care, National Commission on Correctional Health Care, San Antonio, TX.

24—Treating Sleep Disorders in Family Practice, Baylor College of Medicine, Washington, D.C.

24-27—American Group Practice Association, Honolulu.

26—Issues in Graduate Medical Education, American Board of Medical Specialties Research and Education Foundation, Chicago.

26-27—Advances in Cardiovascular Disease, Jewish Hospital Heart and Lung Institute, Louisville, KY.

26-28—American Academy of Facial Plastic and Reconstructive Surgery, Kansas City, MO.

26-28—2nd Annual Conference for the Hearing Impaired: Hearing the Need ··· Answering the Call, WV Hospital Research and Education Foundation and West Virginia University, Morgantown.

26-29—American Academy of Family Physicians, Washington, D.C.

27-28—Diabetes and Peripheral Vascular Disease, Ohio State University, Columbus.

October

4-5—Symposium on Day Care for Children, Institute for Pediatric Service of Johnson & Johnson and American Academy of Pediatrics, Arlington, VA.

4-5—Cardiology Update, Ohio State University, Columbus.

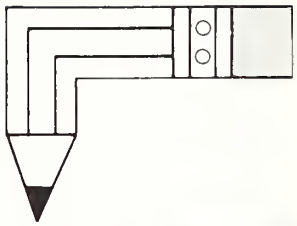
9-13—35th Annual Meeting American Society of Internal Medicine, Washington, D.C.

13-17—American Academy of Ophthalmology and Pan American Association of Ophthalmology Joint Meeting, Anaheim, CA.

For More Information . . .

Contact the Journal for additional information about most of the above meetings. Call (304) 925-0342.

Poetry Corner



Hill Billy

Wind don't blow on me
Rain don't wet my clothes
Sun be good to me
Cause everybody knows
I'm a ring tailed, folded over
Tied in a bundle, son-of-a-gun
From West Virginia and
If my old jallopy just goes
I'll wind up in North Carolina
And I'll be fishing you all know

No spots, no croakers, no catfish, by golly
To catch all those fish would be pure folly
Some Kings, some Dolphin
Or a Striper or Blue
To catch that kind of fish
Is just what I want to do

So wind be good to me
Please blow from the south
That makes the best fishing —
Blows the bait in their mouth

J. Paul Aliff, M.D.

Please address your submissions for Poetry Corner to: Stephen D. Ward, M.D., Editor, West Virginia Medical Journal, Box 4106, Charleston, WV 25364.

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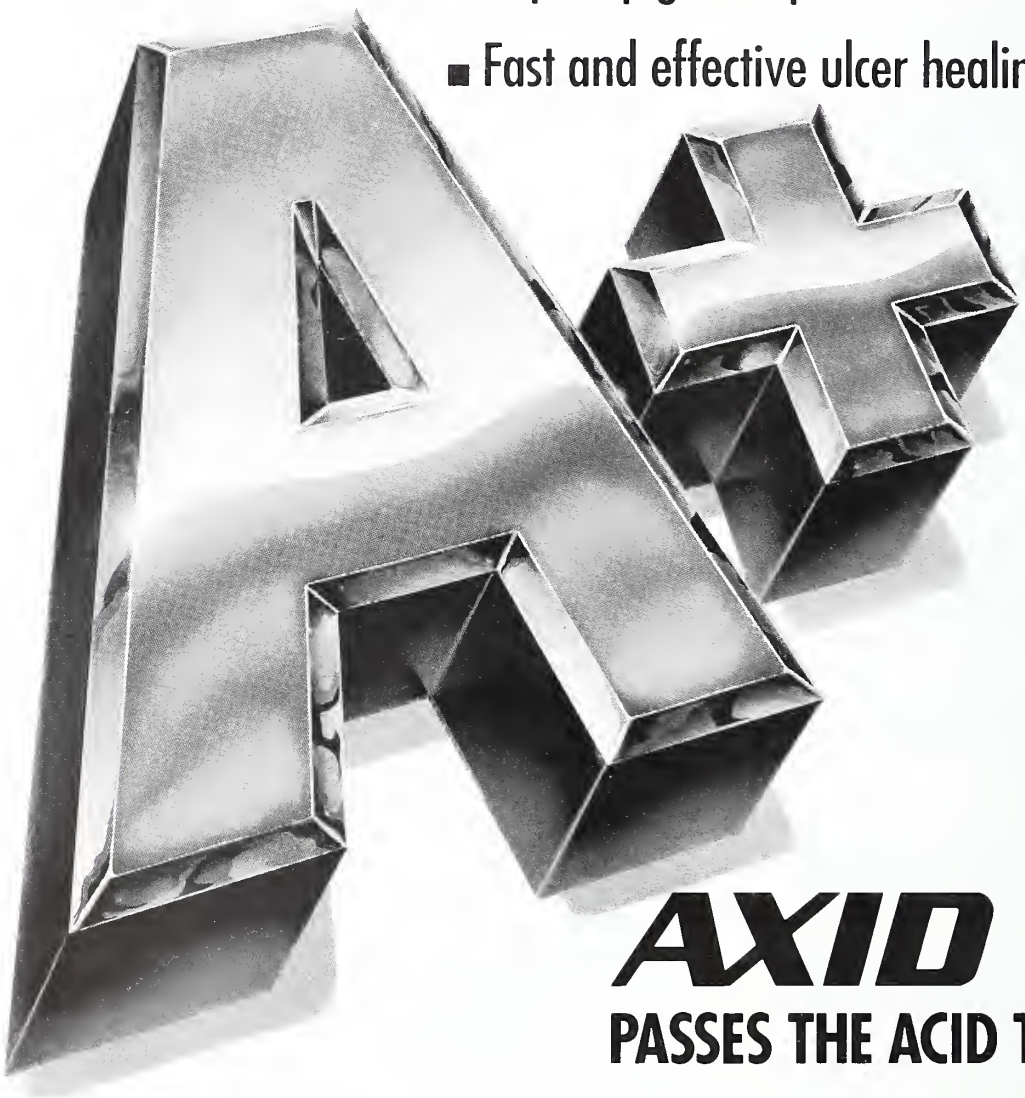

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See adjacent page for references and brief summary of prescribing information.

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2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix® may occur during therapy.

Drug Interactions—No interactions have been observed with theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,900 nizatidine patients and over 1,300 on placebo, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events were due to the drug.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H_2-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H_2-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis does not substantially increase clearance of nizatidine due to its large volume of distribution.

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References

1. Data on file, Lilly Research Laboratories.
2. *Scand J Gastroenterol.* 1987;22(suppl 136):61-70.
3. *Scand J Gastroenterol.* 1987;22(suppl 136):47-55.
4. *Am J Gastroenterol.* 1989;84:769-774.

NZ-2943-B-149347

Additional information available to the profession on request.

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WEST VIRGINIA UNIVERSITY HEALTH SCIENCES CENTER

Compiled from material furnished by the West Virginia University Health Sciences Center News Service, Morgantown.

WVU Hosts Third Rural Health Conference

West Virginia's rural health community will meet at the West Virginia University Health Sciences Center September 22 and 23.

"This is the third year WVU has held a conference for health care workers, policymakers, elected officials and the public on the subject of rural health," Dr. Robert D'Alessandri, dean of the WVU School of Medicine said. "The first year, we concentrated on defining our needs in the state; last year we looked at resources and proposed solutions. This year we are focusing on what approaches have worked in communities across the state, and across the nation."

Among topics slated for discussion are opportunities for "mid-level providers," such as physician assistants and nurse-midwives, to fill gaps in the state's health care network; strategies for rural communities to attract health care providers; and efforts which have improved access to care for rural people.

Community and health care leaders from several West Virginia counties which have made successful changes in the delivery of health care will share their experiences with others from across the state. In addition, medical students from WVU, Marshall and the School of Osteopathic Medicine will tell community leaders what they look for in selecting a place to practice during a forum planned for the second day of the conference.

"I think these conferences have been important in bringing the issue of rural health care to the forefront of public discussion in West Virginia," Dr. D'Alessandri said. "Some of the ideas which people brought to last year's conference have already been implemented, and several important parts of the governor's recent health care and wellness plan grew out of discussions at that conference."

Several task forces on specific aspects of health care in West Virginia which were formed at last year's meeting will provide progress reports on their activities.

For registration information, call the WVU School of Medicine at 293-3460.

Cancer Researcher Named to NIH Study Section

Eric H. Humphries, Ph.D., professor of medicine at WVU and director of scientific affairs at Mary Babb Randolph Cancer Center, has been invited to serve on the Experimental Virology Study Section, Division of Research Grants, of the National Institutes of Health.

Study sections review grant applications submitted to the NIH, make recommendations on these applications to the appropriate NIH national advisory council or board, and survey the status of research in their fields of science.

"Membership on a study section represents a unique opportunity to contribute to the national biomedical research effort," said Fred Butcher, Ph.D., director of the Cancer Center. "These functions are of great value to medical and allied research throughout the world."

Dr. Humphries received his doctorate in molecular biology from the University of Wisconsin and served a postdoctoral fellowship at the Universitat der Zurick, Switzerland. He also received the Jane Coffin Childs Fellowship and an Imperial Cancer Research Fellowship to support three years of work at the Imperial Cancer Research Fund in London.

Before coming to WVU in 1990, Dr. Humphries was associate professor of microbiology at the University of Texas Southwestern Medical Center.

Scholarship Program Assists Med Techs

Two seniors studying medical technology at the West Virginia University Health Sciences Center have been selected for a unique scholarship-loan program provided by WVU Hospitals.

Karen Kurelac of Glen Dale, and Stephanie Michael of Core, will receive loans of up to $1,000 per semester during their final year in school. They also will be eligible to work in the clinical labs at WVU Hospitals for one year after they graduate from WVU's medical technology program next spring. Their loans will be waived if they work in the clinical laboratories continually for at least six months.

Anesthesiologist Joins WVU Faculty

Lynn M. Broadman, M.D., has joined the faculty of the Department of Anesthesiology in the West Virginia University School of Medicine. He holds a joint appointment as a professor of anesthesiology and of pediatrics.

Dr. Broadman is a graduate of the Medical College of Ohio. He completed an internship at the National Naval Medical Center, Bethesda, Md., and fellowships at the University of Virginia and the Children's Hospital National Medical Center in Washington, D.C. He has been a member of the medical staff of the Children's Hospital National Medical Center since 1981.

Dr. Broadman will continue his research into pediatric anesthesiology at WVU. His work in this area, with a subspecialty in pediatric regional anesthesiology, has resulted in two books, more than a dozen scientific articles, and nearly 50 lectures to national audiences.

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MU School Of Medicine News

Compiled from material furnished by the Office of University Relations, Marshall University.

Partnership Program Chosen for National Immunization Effort

A partnership effort by the Marshall University School of Medicine and Valley Health Systems is one of nine selected nationwide as focal programs for the National Immunization Campaign, September 21-29.

"About 50 percent of children in the nation are unvaccinated or undervaccinated by the age of two years, and the situation is even worse in rural West Virginia," said Dr. Joseph Werthammer, chairman of the Department of Pediatrics. "We're going to try to catch up with as many children as we can."

The Huntington coalition co-directed by Valley Health and Marshall is the only program selected that is not in a major urban center. Other cities selected were Chicago, Detroit, Houston, Los Angeles, Miami, New York, Philadelphia and Washington, D.C.

The program is sponsored nationally by the American Academy of Pediatrics and Children's Action Network, an organization of entertainment industry families.

CME Conference Among Events Set for Alumni Weekend

A CME conference whose speakers include many returning Marshall alumni will be one highlight of Marshall's Medical Alumni Homecoming September 27-28.

Other events include talks by West Virginia House of Delegates Speaker Robert "Chuck" Chambers and Dr. Hillard Lazarus of the Cleveland Clinic, recognition of veteran medical educator Dr. Frederick Lotspeich, and the induction of honorary members into the school's Alumni Association.

The weekend's activities start Friday, September 27 with an 8 p.m. student/faculty/alumni mixer hosted by Dr. Patrick I. Brown. The CME meeting begins at 9 a.m. on Saturday, followed by a 12:15 luncheon. A tailgate party will be held before the Marshall vs. Brown football game and all indoor activities will be at the Radisson Hotel. In addition, the classes of 1981 and 1986 also will have reunions during the weekend.

The meeting is open to all West Virginia physicians. More details are available from Peggy Theis at 696-7246.

Lifetime TV Series to Highlight Rural Physician Program

A Lifetime Medical Television series on rural health will include a segment featuring Marshall's Rural Physician Associate Program.

RPAP provides intense rural exposure for selected third-year students, who spend nine months working at a successful small-town health center.

The segment, due to air September 15, will describe ways the state's medical schools are trying to train rural physicians for the next generation, Lifetime researcher Monica Shah said. Later segments in the series will explore occupational and health hazards of farming and trauma in rural areas.

The educational segment will also include Marshall graduate Dr. Michael Kilkenny, a practicing rural physician; Dr. Robert Walker and Dr. John Walden of Marshall's Department of Family and Community Health; and Dr. Jon Lilly, chief resident in Family Practice.

Clerkship Benefits Third-Year Students

Incoming third-year students received "up close and personal" views of primary care medicine through a new, three-week Introduction to Primary Care clerkship.

The clerkship apparently was successful in easing students' concerns about hospital procedures and in providing a positive look at primary care, according to Dr. Linda Savory, assistant dean for curriculum and evaluation.

During the first week, students followed the care of a simulated myocardial infarction patient, spent a day learning alongside nurses, went along on house calls, and listened to lectures from medical faculty and health policy leaders.

In the next two weeks, groups of one or two students went out to work with primary care preceptors. Many students chose physicians from their hometowns.

"We want medical students to see how medicine is practiced in real life, in real communities, by real doctors," Dr. Savory said. "Our state and region have a fine fleet of primary-care doctors, although not enough of them, and we think it's more than appropriate for our students to profit from their experience."

Developmentalist Joins Pediatric Dept.

Dr. Rumie Su, a specialist who treats behavioral and developmental problems of children, has joined Marshall's Department of Pediatrics.

Dr. Su is the only fully trained behavioral developmentalist in West Virginia and she will work with children who have problems such as mental retardation or cerebral palsy, according to Dr. Joseph Werthammer, chairman of pediatrics. She hopes to develop a program for children with multiple handicaps or who are chronically disabled, he added.

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Obituaries

Preston C. Davis, M.D.

Dr. Preston Caldwell Davis, 75, of Beckley, died July 14, in a Princeton hospital, following a long illness.

Dr. Davis was a lifelong resident of Beckley, where he was a member of the St. Stephens Episcopal Church. He was a graduate of Woodrow Wilson High School, earned an A.B. degree from West Virginia University, a B.S. degree from West Virginia University School of Medicine and his M.D. degree from the Medical College of Virginia in 1951.

Upon graduation from medical school, Dr. Davis did his internship and residency in the Department of Medicine at Charleston General Hospital and then continued his residency in the department of medicine at the Beckley Memorial Hospital.

Dr. Davis was board certified by the American Board of Internal Medicine and recertified in 1978. He practiced medicine in various coal camps in Raleigh County and was a staff physician at the Pinecrest Sanitarium in Beckley. An associate physician with the Charles Griffith Clinic in Mount Holly, Va., Dr. Davis was also affiliated with the departments of medicine at Beckley Memorial Hospital and Southern West Virginia Clinic.

Dr. Davis held appointments as the physician for Raleigh and Fayette Counties; commissioner of health for the Beckley City Police Department and program director for the Internal Medicine Residency Program at Beckley Appalachian Regional Hospital, where he also served as chief of medicine from 1968 to 1976.

Dr. Davis was a past president of both the Raleigh County Medical Society and the West Virginia Thoracic Society. He was also a member of the American Society of Internal Medicine, a Fellow in the American College of Physicians and was a member of Phi Beta Pi.

Survivors include Blanche "Nancy" Cummins Davis of Maxwell Hill; three daughters, Mrs. William (Libby) Kelly of Shady Spring, Mrs. Bill (Becky) Burgess of Stanaford Acres, and Dr. Susan Caldwell of Montgomery, Ala.; and three grandchildren.

George Adam Miller, M.D.

Dr. George Adam Miller, 83, of Beckley, died April 13 in a Beckley hospital.

Born at St. George, Dr. Miller was a graduate of Parsons High School and was a veteran of World War II serving in the Army with the rank of Lieutenant Colonel.

Dr. Miller studied pre-med at West Virginia University and was in Alpha Epsilon Delta Medical Honorary Society. He was a graduate of the University of Louisville Medical School where he was a member of the Alpha Omega Alpha.

Dr. Miller was an eye, ear, nose and throat specialist until his retirement in 1979. Dr. Miller last worked at the Beckley Medical Arts and was also affiliated with the Veterans Area Medical Center, the Beckley Appalachian Regional Hospital and Raleigh General Hospital. He was a member of the Raleigh County Medical Society and the United Methodist Temple.

Survivors include his wife of 50 years, Olive Tillson Miller of Beckley; two sons, Lawrence E. Miller of Beckley and Vincent W. Miller of Ghent; a daughter, Carol J. Huffman of Beckley; three grandchildren, Jennifer, John and Debby; four brothers, Paul Miller of Murrieta, Ca., Elmo Miller of Brewston Mills, Virgil Miller of Paoli, Ind., and Ralph Miller of Morganton, N.C., and two sisters, Elsie Harrald King of Prussia, Pa., and Mrs. John (Ruth) Geer of Elkins.

Stephen Crail Rector, M.D.

Dr. Stephen Crail Rector, associate professor of surgery and internal medicine at West Virginia University, died July 20 at his residence after a lengthy illness.

Dr. Rector was born in Benton Harbor, Mich., and was a 1962 graduate of Homewood-Flossmore High School in Illinois. He earned a B.A. degree from Carleton College in Northfield, Minn., and an M.D. degree from the University of Minnesota. He completed his residency at WVU in 1983 and joined the faculty.

Dr. Rector was medical director of the Emergency Department at WVU Hospitals until he became ill in 1990. He was among the founders of HealthNet, the emergency medical helicopter service, and was president of the West Virginia Chapter of the American College of Emergency Physicians. He also served on the medical staffs of Davis Memorial Hospital and Camden-Clark Memorial Hospital in Parkersburg.

Widely known and respected for his teaching and clinical activities, Dr. Rector often instructed practicing physicians and emergency medical providers in techniques of trauma and cardiac life support. Earlier this year, colleagues and staff members at the WVU Health Sciences Center honored him with the establishment of the Stephen C. Rector Visiting Lectureship in Emergency Medicine.

Dr. Rector was a member of the Society for Academic Emergency Medicine, the Monongalia County Medical Society and Physicians for Social Responsibility. He was also a member of the West Virginia Safety Belt Coalition, the Nature Conservancy and the Cooper's Rock Coalition.

In addition to his parents, Dr. Rector is survived by his wife, Nancy; one son, James, and one daughter, Katherine.

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Annual Audit 1990

The annual audit of the West Virginia State Medical Association for the calendar year 1990 has been completed by Ernst & Young of Charleston. The complete audited financial statements including the report of independent auditors is as follows:

REPORT OF INDEPENDENT AUDITORS

To the Council
West Virginia State Medical Association
Charleston, West Virginia

We have audited the accompanying balance sheets of the West Virginia State Medical Association as of December 31, 1990 and 1989, and the related statements of revenues and expenses—unrestricted fund, changes in fund balances, and cash flows—unrestricted fund for the years, then ended. These financial statements are the responsibility of the Association's management. Our responsibility is to express an opinion on these statements based on our audits.

We conducted our audits in accordance with generally accepted auditing standards. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the West Virginia State Medical Association at December 31, 1990 and 1989, and the results of its operations and its cash flows for the years, then ended in conformity with generally accepted accounting principles.

Ernst & Young

April 5, 1991

BALANCE SHEETS
WEST VIRGINIA STATE MEDICAL ASSOCIATION

UNRESTRICTED FUND	December 31 1990	1989
ASSETS		
Cash and cash equivalents	$ 194,872	$ 565,727
Investments (cost $200,035 as of December 31, 1990 and 1989)—Note A	193,917	193,917
Notes receivable, less allowance for doubtful accounts of $65,000 and $50,000 for 1990 and 1989—Note E		10,000
Accounts receivable	28,225	13,225
Other assets	1,306	6,714
Land, building, and equipment—Note B	696,427	725,653
	$1,114,747	$1,515,236
LIABILITIES		
State and American Medical Association dues collected in advance	$ 157,980	$ 191,930
Medical scholarship obligation	16,663	24,163
Accounts payable	12,985	33,829
Accrued income taxes payable—Note G	18,329	114,477
Accrued interest payable—Note G	1,748	57,248
Accrued expenses and other liabilities	61,833	73,125
Note payable to bank—Note D	525,021	525,021
	794,559	1,019,793
FUND BALANCES		
Undesignated	313,911	489,166
Designated for professional liability education—Note A	12,395	12,395
Unrealized depreciation on equity securities	(6,118)	(6,118)
	320,188	495,443
	$1,114,747	$1,515,236
RESTRICTED FUND—NOTE A		
ASSET		
Investment in common stock	$ 4,250	$ 4,250
FUND BALANCE		
Endowment	$ 4,250	$ 4,250

See notes to financial statements.

STATEMENTS OF REVENUES AND EXPENSES—UNRESTRICTED FUND
WEST VIRGINIA STATE MEDICAL ASSOCIATION

	Years Ended December 31 1990	1989
REVENUES		
Dues	$ 552,881	$ 563,721
Professional liability services—Note F	140,000	140,000
Interest and investment	42,351	65,117
Exhibit space income	41,300	41,850
Advertising	45,388	35,068
Registration fee income	22,145	21,270
Contributions	16,353	14,159
IC Systems commission income	8,637	11,651
Other revenues, including grants from Endowment Fund of $1,472 and $1,408 in 1990 and 1989	20,574	17,984
TOTAL REVENUES	889,629	910,820
EXPENSES		
Salaries and wages	294,583	293,137
Interest expense—Notes D and G	61,301	116,696
Publishing and printing	105,454	105,402
Convention speakers and supplies	91,137	91,864
Legal and accounting	57,955	86,520
Travel	80,370	81,400
Malpractice	23,550	69,591
Employee benefits—Note H	61,882	66,091
Depreciation and amortization	47,964	59,512
Legislative liaison retainer		35,000
Postage	29,456	20,939
Payroll taxes	23,232	18,702
Consultant retainer	7,460	16,126
Office supplies	23,163	13,653
Telephone	17,200	13,404
President's stipend	20,000	10,000
Bad debt expense	15,000	
Property taxes	8,806	9,133
Liability insurance	8,955	7,562
Medical students'/residents' subsidies	11,205	7,393
Computer repairs and maintenance	6,885	6,915
Utilities	6,634	6,550
Other expenses	79,278	55,725
Refund of expenses	(23,803)	(17,273)
TOTAL EXPENSES—NET	1,057,667	1,174,042
EXCESS (DEFICIENCY) OF REVENUES OVER EXPENSES BEFORE TAXES	(168,038)	(263,222)
Federal and state income tax provision—Note G	7,217	114,477
EXCESS (DEFICIENCY) OF REVENUES OVER EXPENSES	$ (175,255)	$ (377,699)

See notes to financial statements.

STATEMENTS OF CHANGES IN FUND BALANCES
WEST VIRGINIA STATE MEDICAL ASSOCIATION

	Unrestricted Fund	Restricted Endowment Fund
Balance at December 31, 1988	$ 863,411	$ 4,250
Excess (deficiency) of revenues over expenses	(377,699)	1,408
Change in unrealized loss on equity securities	9,731	
Grant to unrestricted fund		(1,408)
Balance at December 31, 1989	495,443	4,250
Excess (deficiency) of revenues over expenses	(175,255)	1,472
Grant to unrestricted fund		(1,472)
Balance at December 31, 1990	$ 320,188	$ 4,250

See notes to financial statements.

STATEMENTS OF CASH FLOWS—UNRESTRICTED FUND
WEST VIRGINIA STATE MEDICAL ASSOCIATION

	Years Ended December 31 1990	1989
OPERATING ACTIVITIES		
Excess (deficiency) of revenues over expenses	$ (175,255)	$(377,699)
Adjustments to reconcile net (loss) to net cash used in operating activities:		
Depreciation and amortization	47,964	59,512
Provision for bad debt expense	15,000	
Loss on disposal of fixed assets		1,377
(Increase) in accounts and notes receivable	(20,000)	(15,571)
Decrease in other assets	5,408	4,371
(Decrease) increase in State and American Medical Association dues collected in advance	(33,950)	11,030
(Decrease) increase in income taxes payable	(96,148)	114,477
(Decrease) increase in accrued interest payable	(55,500)	51,001
(Decrease) in medical scholarship obligations	(7,500)	(10,950)
(Decrease) increase in accounts payable	(20,844)	20,268
(Decrease) increase in accrued expenses and other liabilities	(11,292)	30,702
NET CASH (USED IN) OPERATING ACTIVITIES	(352,117)	(111,482)
INVESTING ACTIVITIES		
Purchases of equipment	(18,738)	(4,130)
NET CASH (USED IN) INVESTING ACTIVITIES	(18,738)	(4,130)
FINANCING ACTIVITIES		
Net proceeds from refinancing note payable to bank	14,979	
Repayment of note payable to bank	(14,979)	(305)
NET CASH (USED IN) FINANCING ACTIVITIES		(305)
(DECREASE) IN CASH	(370,855)	(115,917)
Cash and cash equivalents at beginning of year, as previously reported	565,727	663,520
Effect of merger with Properties—Note E		18,124
CASH AND CASH EQUIVALENTS AT BEGINNING OF YEAR AS RESTATED	565,727	681,644
CASH AND CASH EQUIVALENTS AT END OF YEAR	$ 194,872	$ 565,727

See notes to financial statements.

NOTES TO FINANCIAL STATEMENTS
WEST VIRGINIA STATE MEDICAL ASSOCIATION

December 31, 1990

NOTE A—SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Cash and Cash Equivalents: Cash and cash equivalents are comprised of short-term certificates of deposit at cost, which approximates market.

Investments: Investments consist of approximately 17,300 shares of a Federated GNMA Trust which are stated at the lower of cost or market value. There were no sales of investments in 1990 or 1989. Unrealized gains and losses on equity securities are credited or charged directly to fund balance. The gross unrealized loss on equity securities was $6,118 at December 31, 1990 and 1989, respectively. Gross unrealized securities gains and losses through April 5, 1991, are not material.

Land, Building and Equipment: Land, building, and equipment are recorded at historical cost. Depreciation is computed by the straight-line method using estimated useful lives ranging from 5 to 35 years. The cost of maintenance and repairs is charged to income as incurred and significant renewals and betterments are capitalized.

Allowance for Doubtful Accounts: The Association values its notes receivable at net realizable value by expensing amounts determined to be uncollectible in the period of determination.

Medical Scholarship Obligation: Until 1987, the Association provided scholarships to students attending Schools of Medicine at West Virginia and Marshall Universities for the purpose of defraying expenses incurred by such students. A liability for the remaining scholarship obligation is a part of the general fund.

Fund Balance: The Association has designated a special assessment fund to be used for professional liability education. The fund is to be used to inform physicians about current and potential problems with malpractice insurance and is accounted for in the unrestricted fund.

The Endowment Fund, a restricted fund, was established to pay for the guest speaker at the annual meeting and consists of equity securities stated at cost, which approximates market.

Recognition of Revenue: Members are billed in October for the subsequent year's dues, which are treated as earned in the period to which they relate. All dues received prior to January 1 are reported as dues collected in advance.

Reclassifications: Certain amounts reported in 1989 have been reclassified to conform with 1990 presentation. Such reclassifications have no impact on excess of expenses over revenues.

NOTE B—LAND, BUILDING AND EQUIPMENT

A summary of land, building, and equipment and the related allowance for depreciation as of December 31 is as follows:

	1990	1989
Land	$ 141,247	$ 141,247
Building and improvements	635,585	635,585
Furniture and equipment	209,686	190,948
	986,518	967,780
Less allowance for depreciation	(290,091)	(242,127)
	$ 696,427	$ 725,653

NOTE C—FUTURE MINIMUM RENTALS UNDER OPERATING LEASES

The Association leases office and computer equipment under noncancellable operating leases with terms of one year or more. The following is a schedule by years of minimum future rentals on these leases as of December 31, 1990:

Year ending December 31:	
1991	$11,700
1992	10,300
1993	3,600
1994	2,700
Total minimum future rentals	$28,300

Total minimum future rentals do not include contingent rentals which may be assessed under the office equipment lease on the basis of usage in excess of stipulated minimums. Contingent rental expense in 1990 and 1989 approximated $400.

Rental expense in 1990 and 1989 approximated $9,000 and $1,300, respectively.

NOTE D—DEBT

The Association and West Virginia State Medical Association Properties, Inc. (Properties) merged in February 1989. In conjunction with the merger, the Association assumed Properties' note payable to bank. In January 1990, the Association refinanced its note payable to bank. The amount refinanced was $540,000. Terms of the agreement provide for interest at 10% with monthly installments of $5,211 (including principal and interest). Terms of the agreement before refinancing provided for interest at 7.5% to 14% with monthly installments of $5,500 (including principal and interest). The loan is collateralized by a first deed of trust on the building which had a net book value of approximately $522,000 at December 31, 1990 and $528,000 at December 31, 1989.

Notes payable to bank maturing in the next five years consist of:

1991	10,502
1992	11,602
1993	502,917
	$525,021

Interest paid approximated $68,000 and $71,500 in 1990 and 1989, respectively.

NOTE E—RELATED PARTY TRANSACTIONS

West Virginia State Medical Association Properties, Inc. (Properties) was formed during 1980 to acquire land and construct an office building for the Association. This project was completed during 1985. In conjunction with this activity, the Association collected assessments on behalf of Properties and also made various cash advances to Properties through the project completion date.

On February 2, 1989, Properties was merged into the Association. At that time, Properties ceased to exist as a separate entity and its assets, liabilities,

and fund balance were assumed by the Association. All assets and liabilities of Properties were recorded by the Association at their net book values.

In 1986, the Association approved a $50,000 line of credit to Preferred Medical Care Network of West Virginia, Inc. (PMCN), a preferred provider organization established to benefit Association members. This line of credit was fully drawn down to assist PMCN with initial start-up costs. In April 1989, the Association approved an additional $25,000 line of credit to PMCN. As of December 31, 1990, the Association had advanced $15,000 under this additional line of credit resulting in a gross note receivable of $65,000. During 1990, PMCN ceased operations and management has determined that PMCN will likely not be able to repay the amounts advanced to them. Accordingly, full provision for these amounts has been made in the financial statements.

NOTE F—PROFESSIONAL LIABILITY SERVICES

The Association has separate agreements with Continental Insurance Agency (CNA) and McDonough Caperton Insurance Group, L.P. (MCIG) to provide educational and marketing services to the Association's members relating to professional liability insurance. Under the terms of the agreements, the Association is to receive up to $100,000 a year from each company. The Association recognized income of $100,000 from CNA and $40,000 from MCIG in 1990 and 1989.

NOTE G—INCOME TAXES

Revenues of the Association are generally exempt from federal income tax under Section 501 (c) (6) of the Internal Revenue Code. However, certain income, primarily advertising revenues and income received under agreements with insurance providers for their educational and marketing services and use of the Association's membership lists, is considered unrelated business income and is taxable to the extent it exceeds allocable expenses.

In 1988, the United States Tax Court, and in 1989, the 4th Circuit Court of Appeals, held that the Association's losses from advertising activities do not constitute net operating losses available for deduction from other related business income. Subsequently, the Association lost its appeal of the 4th Circuit's decision to the U.S. Supreme Court in early 1990. Accordingly, a provision for the resulting federal and state tax liability has been included in the financial statements. Federal and state taxes, and past-due interest for the years ended December 31, 1984 through 1989, paid in 1990 approximated $103,000 and $49,000, respectively.

NOTE H—RETIREMENT PLAN

The Association is a participant in the Prototype Corporate Defined Contribution Retirement Plan of One Valley Bank (the Plan). All employees of the Association are covered by the Plan as long as they are at least twenty-one years old and have completed six months of service. The Association's contribution approximated $21,000 and $24,000 in 1990 and 1989, respectively, based on 10% of the total compensation of all eligible participants. Employees are vested in their participant account at the rate of 20% for each completed year of service up to 100% vesting after five years of service.

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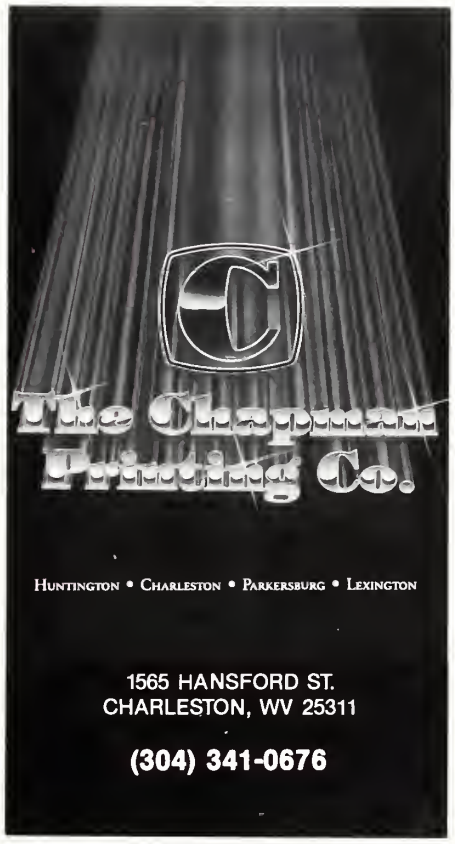

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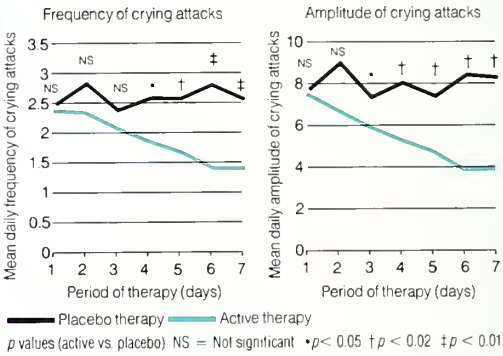

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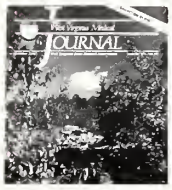

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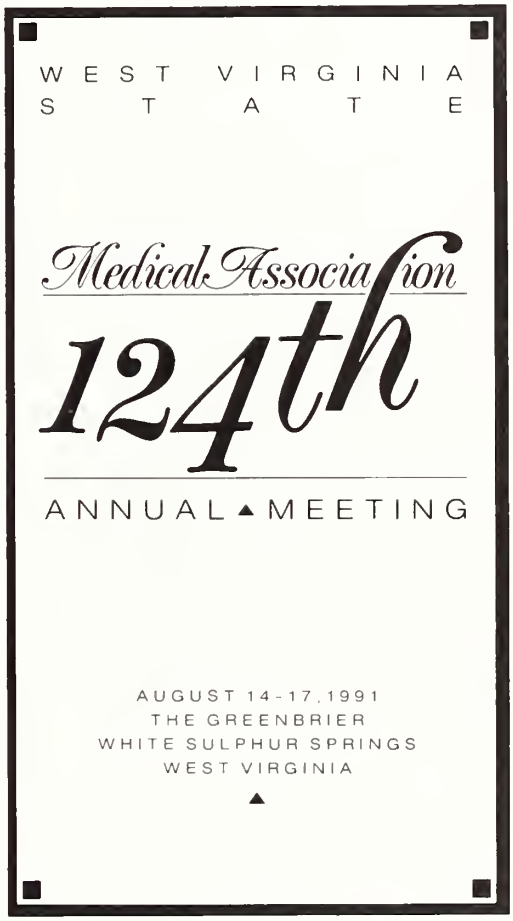
SPECIAL SECTION

Convention Report

West Virginia State Medical Association
124th Annual Meeting

August 14 - 17, 1991
The Greenbrier
White Sulphur Springs, West Virginia



A special thank you is extended to the numerous participants in the WVSMA's 124th Annual Meeting. Your commitment strengthens the Association and is vital to its success.

Inaugural Address

Annual Meeting 1991

Only In America

CONSTANTINO Y. AMORES, M.D.
President,
West Virginia State Medical Association

A while back, my family and I were traveling in the panhandle of West Virginia, when my youngest son, Christopher, spied a turtle on top of a fencepost. He asked, "Dad, how did the turtle get up there?"

I told him someone helped that turtle, but then I saw in my rear view mirror, kids on the other side of the road throwing rocks at the poor turtle.

Twelve years have since past, and I realize that I too, sometimes feel precarious sitting atop the fencepost. However, Dr. Mike Stump assured me that he took care of all the problems during his presidency last year. Yet, somehow I suspect, there will be many rocks thrown my way.

I am humbled by the honor this House of Delegates has accorded me. To accept this presidency, reaffirms the beliefs that have kept me from falling off the fence.

This poor turtle is up here mainly because of the support of my wife, Diana. Even as a radiologist and mother, she always made time to make sure I wasn't teetering.

Allow me to share with you my strengths: My oldest son, Tino Jr., whose high expectations took him to Notre Dame, Loyola Law School, and Harvard, where he met his wife, Janet. Tino Jr. practices law in Charleston and Janet recently blessed us with our newest family addition, Tino III.

My eldest daughter, Annabelle, a graduate of St. Mary's of Notre Dame and her husband, John Walsh, also from Notre Dame, have made the Amores clan very proud with our first grandchild, John Jr.

Our grandsons, have given us a new dimension in life. Had I known what a pleasure it would be to have grandchildren, I would have skipped kids.

Of course, there is Ange. I am very proud of Ange's achievements. She took her journalism degree to Chicago, first as a reporter, and now as an assistant press secretary to Chicago's Mayor Daley.

My youngest son, Christopher, recently finished his undergraduate studies. He is at a crossroads in life. I know his altruistic nature will take him down the right path.

These are my beacon light, my inspiration.

I would like to pay respect to my father who died before seeing the fruits of his toils. I have the utmost respect for any man who manages to send to school three doctors, a lawyer, an engineer, and a couple of CPAs, on a university professor's meager salary.

Dr. Constantino Amores proudly takes the podium to deliver his inaugural address as the House of Delegates and other members of the audience give him a standing ovation.

My deepest reverence also goes to my 84-year-old mother, who could not be here today. When she told us to reach our dreams, she did not realize that we'd reach as far as America.

Growing up in a family of nine, the budget was tight. I would like to acknowledge my brother, Al, who was deprived when my parents sent me to medical school. I am grateful for his patience. Al is a plastic surgeon now.

My parents raised us in the belief of the omnipotence of God and, in the principle that we must return our fortunes back to the community that helped us to be so blessed.

Professionally, I would like to recognize Dr. George H. Gray Jr., my neurosurgical mentor and friend, who singled me out among others for his program. In addition, Dr. Carrell Caudill, and his associates, Drs. Withrow, Poffenbarger, Teodoro, Clubb and Velasquez, who welcomed me into their group in Charleston. My special thanks also go to:

-- Dr. John Tew, our Thomas L. Harris lecturer this year, who is a past president of the Congress of Neurosurgical Surgeons, for his friendship and encouragement. John is a model neurosurgeon.

-- Dr. Glenn Crotty, who was the first to submit my name for nomination.

-- Dr. James Kessel, who believed in my capabilities to lead the society.

-- The Kanawha County delegation for backing my nomination and,

-- My many friends whose continued backing has supported me through my trials, as well as my blessings.

Since I have accepted this position, many people have asked me, "Why would you take on this role with all the hardships that lay ahead?" I tell them that the history of the West Virginia State Medical Association is reassuring.

I must reflect with you the uncanny similarities that I share with three of our past presidents: Dr. William J. Bates, the father of the WVSMA; Dr. James Braumfield, who was president of this association in 1891; and Dr. Charles Summerfield Hoffman, president of this association at the turn of the century.

Over 124 years ago, Dr. William J. Bates, the father of our society, was in the same predicament that we are in today with state government obstructing our role to provide West Virginians with the best health care.

In an effort to correct that dilemma, Dr. Bates sent a letter to all the doctors in the state to organize this association. He wrote that the WVSMA must elevate "the standard of practical medicine and surgery in West Virginia and to render quackery odious as it deserves. The want of the WVSMA is severely felt by all true cultivators of our noble science. Disease and deaths do not relax in their hold in favor of our mountains and valleys. On the contrary, some of these are the very stronghold of the enemy. The inhabitants must be taught the laws of hygiene and be able to mark the differences in the intelligent physician and the murderous pretender, who is ever present with the offer of his ignoble service."

Dr. Bates wrote this in 1867, yet we are confronted by the same quandary with today's government trying to give licenses to non-MDs. It would be "rendering quackery odious."

Politicians, plaintiff's lawyers, third parties and their PROs are in no position to be telling us which treatment our patients need and how long they should be treated.

One hundred years ago, Dr. James Braumfield was elected president of this organization. Realizing the governmental influence in the practice of our profession, in 1894, he ran and was successfully elected a member of the House of Delegates for Marion County.

It is the same old story, isn't it? We also spar with government obstructing our profession today.

One of the major issues I also contend with is the *West Virginia Medical Journal,* of which Dr. Braumfield was a founding member of the *Journal* committee.

Dr. Braumfield recognized the significance of communication among members, so he started the *West Virginia Medical Journal* as a quarterly publication in 1906. A year after its successful debut, the *Journal* was published as a monthly. To this day, it has been published in that form. It would be a mistake to change it now.

At the turn of the century, Dr. Charles Summerfield Hoffman was inducted as president. A skillful surgeon for the B & O Railroad, he eventually established the Hoffman Hospital in Keyser, W.Va.

In his hospital alone, he performed 7,000 operations. He also managed to pen "Gunshot Injury to the Brain." I wonder what he did then. As Ambrose Perry said, "We dress the wound, God heals the patient." There were many of those then.

One hundred years later, with expertise handed down to us, diagnostic capabilities never before imagined, and results of treatment today that would be considered miraculous then, I ask, "Are there problems in the House of Medicine?"

No, there aren't any. We should not have any problems if society would only allow us to practice our profession unencumbered.

I consider myself at an advantage because I have seen both sides of medicine. Where I come from in the Philippines, and in many places of the world, medicine is barely above a very basic level. I would challenge any of the critics of American medicine to come with me on any of the medical missions I go on each year. I can assure you, they will appreciate our system better. I would dare say, if anyone of our critics get sick, seriously sick abroad, they would fly back or wish they were in America.

Despite the lack of modern technology, the physicians over there practice the art of healing better than you or me. Their patients are unabashedly appreciative of them.

This is what this organization must pursue. We must let our patients know that we are their friends, their confidants, a source of comfort to have when they are sick. Only then, can we do better than just, "We dress the wound, God heals the patient."

We must never allow government intrusion and third party intervention to spoil our basic art of the healing profession.

Let me serve notice, though, to anyone concerned that this gentle approach to medicine is neither a retreat -- nor a sign of weakness. We will confront, influence, argue, and stand steadfast in our endeavors against anyone who prevents us from providing West Virginians the best medical care we know how.

After each return from a medical mission, the more I realize how fortunate we are in America and in West Virginia for that matter, to possess medical capabilities that other countries can only hope to equal one day.

Today is the 124th time this torch of leadership is handed over. I accept this challenge and with all my energies and faculties, I intend to keep this torch of leadership brightly lit.

From my simple upbringings, I consider this honor a tribute to the American dream -- ONLY IN AMERICA!!!

I will sincerely say to you, I love this country, I love West Virginia and I am proud of being a physician. I will live up to the responsibilities of this position, so help me God.

Farewell Address

Annual Meeting 1991

The President and the Office

MICHAEL M. STUMP, M.D.
1990-91 President, West Virginia State Medical Association

I should like to present to you the individual without whom there would be no me — my wife of forty plus years — Priscilla Ann Connell Stump.

Next, I should like to present to you my youngest light who has delayed returning to school to be with me this week — Laurie Marie Stump.

To the others of my family who could not be here for varieties of reasons, I send my love. Both my mother and father who are long deceased are here today in my memory and I know they are very happy and proud.

By way of introduction to my subject today "The President and the Office," I should like to offer you a particular definition of a physician. It is not original with me but I have taken it for my own — "A Physician Is What A Physician Does."

By logical extension, the medical profession is what the medical profession does, and by further extension the president is what the president does.

The members of the House of Delegates of the West Virginia State Medical Association are chosen by the members of local county medical societies who are also members of the West Virginia State Medical Association. These delegates articulate the goals and beliefs of their fellow physicians and serve them by determining WVSMA policies at annual or called meetings of the House.

The president of the WVSMA is the physician member you have elected and directed to represent and speak for you in accordance with the principles and policies determined by you. Upon this individual you bestow great esteem and responsibility. I was and continue to be highly honored that you chose me from among yourselves to serve you. I have done my best to be a credit to you. There are many members who could have equally filled or better filled this office than I.

We have an abundance of outstanding, hard working, dedicated physicians in our state who care about our profession. Many are here today and some have not yet arrived.

As these physicians work up the ladder of organized medicine and gain the necessary experience and development, you will have excellent choices. One of those choices is your President-Elect Dr. Tino Amores, who will be installed later this week as your president.

There should be no lack of qualified leadership now or in the future as you choose from among yourselves those who are to serve you.

Your president must be a servant. That person must have no private agenda. The president must put aside personal desires, ambitions, biases and adopt the mantle of service. The primary obligation of the president is to the members of the WVSMA.

In his farewell address, Dr. Michael Stump recapped many of the challenges he faced during his year as WVSMA president.

The president must carefully measure and weigh all decisions, recommendations and actions by the standard of what best serves all WVSMA members, even while taking proper care to protect the legitimate interests of the majority and the minority.

The manner of how the president serves will be a matter of that individual's personal style in harmony with the goals and directives of the membership.

I had concluded that my most comfortable personal style was natural West Virginia toughness and honesty, and even willingness to fight while at the same time always being prepared to be reasonable and fair. In this, I always demanded the WVSMA's goals be first and foremost.

During my term of office there have been very many occasions to think, to evaluate, to speak and to act.

These opportunities have been far more frequent than I ever wanted, imagined or even dreamed of a year ago.

In line with the definition that a president is what a president does, it might be interesting to recount some of the presidential adventures that stand out in my mind. I know I cannot convey to you all the energy, effort and hours that all of us put into these events,

nor even all the adventures themselves, so I shall just relate the highlights of a few of them.

The first adventure quickly came out of the blue in August of last year when your Chief Executive Officer George Rider asked me to appear at the Capitol to speak on a bill that was being rushed through a special session of the Legislature. This bill was SB 5 (HB 305) which appointed a PEIA Finance Board to have sole control of PEIA monies apart from legislative oversight.

Of course, it went through hands down, but I was able to point out to the Legislature that the WVSMA had not been consulted at anytime and actually only found out about it at the last minute. I further addressed this issue to the membership as an insert in a *WESGRAM* letter that went out shortly thereafter.

Then, in late September and early October, I received word of the collapse of Blue Cross and Blue Shield of West Virginia. On behalf of the WVSMA, I was not willing to take this lying down and reacted quickly.

While a guest at the annual meeting of the West Virginia Hospital Association, word was received that the acting secretary of the treasury would like to meet with the WVSMA. I invited him to the Executive Committee retreat the first weekend in October and the Blue Cross and Blue Shield issue naturally became the major issue among the many other agenda items discussed that weekend.

Shortly thereafter, several blunt but polite meetings were held over a 10-day period with many state government representatives, including the acting Secretary of the Treasury, the Insurance Commissioner and the Attorney General. I think the kind of exchanges we had are called frank discussions in diplomatic language. They insisted upon a commitment that physicians would forgive all Blue Cross debts and we refused to recommend this; but assured them that all physicians would be generous and compassionate as they have always been, and would as usual, consider their patients debts on a case-by-case basis.

We also promptly filed for appropriate legal remedies in the liquidation proceedings concerning Blue Cross and Blue Shield and these are ongoing today.

I learned about interviews during this time since I was contacted by many national and state news organizations, newspapers, news journals, and radio and television stations.

The varieties of inquiries and their nuances got my complete attention and awakened my full sensitivities about possible mistakes and errors which, I can assure you, kept me on my toes and very careful.

Abundant material and information came to me from near and far during this time. Some of it was unsolicited, but all was very useful in helping me to understand and grasp more fully the nature of the Blue Cross issue.

It was now about December and a health care task force was created without physician representation. We immediately raised strenuous and repeated objections about the failure to appoint physicians to this task force and, indeed, the next appointed task force had physician, as well as hospital representation.

The Legislative Session for 1991 began in January and by now we had the full-time service of our Associate Executive Director Thom Stevens, who had extensive government relations experience and legislative expertise. We had two meetings with the governor's assistants regarding a variety of matters and it become crystal clear that our job would not be easy. Additional lobbyists had also been retained by this time to complement and supplement our in house team. The money and initiative for this came mainly from individual and group contributions over and above the increased dues which had been put into place by this House.

All persons representing the WVSMA at the Legislature met and agreed to be subject to and follow the decisions and policy directives of the president. Strategic and tactical decisions were not arrived at lightly. They were arrived at only after consideration of the goals and the best interests of the WVSMA, and in accordance with the stated will of this House.

Considerable input was solicited and received from team members as to how to best accomplish our goals. There was a willingness to fight to the end if necessary, along with an attitude of firmness, toughness and reasonableness. If it was necessary to be adversarial, we were adversial. If it was necessary to have a high profile or a low profile, we had a high profile or low profile. If a compromise on a lesser issue was necessary to gain a greater issue, then we were accommodating. We strived to be reasonable, fair and serve the interests of the WVSMA and our patients at the same time, so we could have the best of all worlds.

This is the stance we adopted and the image we cast. I believe we got everyone's attention and didn't lose any ground. We even gained a few legislative successes along with new recognition, understanding and possibly a bit of respect.

The WVSMA is today recognized by the Legislature and government as a reasonable and effective entity with which they can, and must work, if there is to be a successful and productive health climate. We can now more openly talk to each other as we address some of the common problems of the health of our citizens.

For example, during the legislative session, arrangements were made for the WVSMA's Legislative Committee, subcommittees and staff to sit and work with state legislative members and staff after the session ended. These meetings have been frequent and productive, enabling everyone to know and understand each other better. They have arrived at some potential solutions to grievous health care problems. Some of the results of their work and proposed solutions will be freely debated during this annual meeting.

Finally, at a news conference last week, I was happy to compliment the Legislature and the governor on behalf of the WVSMA as well as 64,000 health care workers. The occasion was the carrying out of the Legislature's instruction that the first $21 million from any year-end state budget surplus be used to obtain matching funds from the federal government. The federal match for West Virginia is 3.2 to 1 for a total amount of about $85 million in Medicaid monies. This may help some physicians to stay in West Virginia, add additional employees, expand services, or replace old equipment.

I have not mentioned many other activities and some events I have written about in my monthly *Journal*

(Continued on page 452)

The Power of Our Profession: HIV-Testing, Payment Reform and Access To Care

JOHN J. RING, M.D.
President, American Medical Association

It is good to be back in West Virginia, a state with which I have many special ties. For instance, my 90-year-old mother was born and raised in Clarksburg. It is also a great privilege to start my official travels as the American Medical Association president at The Greenbrier. The Greenbrier is a great place to start things -- I speak from personal experience since Anne and I honeymooned here 37 years ago.

This year, I have chosen professionalism as the theme for my presidency. By professionalism, I mean that dedication to competence, compassion and moral accountability that has characterized the best doctors in every era since Hippocrates. Professionalism is our very identity as doctors.

The basic act of professionalism is a doctor looking after a patient -- the doctor-patient relationship. We can accept nothing that threatens this relationship by trying to turn medicine into a mere trade, a dispassionate business venture, an impersonal public utility. We can accept nothing that threatens this relationship by maneuvering us to work for anyone other than our patients. We can accept nothing that threatens this relationship by trying to make us agents of any effort that would violate our duty to do no harm. For example, by asking us to ration needed care, to assist in suicide or to kill people in state-sanctioned executions.

Today, I would like to talk with you about three particular topics, and I would like to put them in the context of professionalism. These topics are HIV testing, physician payment reform and access to care. They go right to the heart of what being a doctor is all about.

On the topic of HIV, I wonder if any of you have heard about a letter written to President Bush by an Eastern Kentucky woman named Belinda Mason? Mrs. Mason describes herself as "a hillbilly, a small-town journalist and a reliable Tupperware guest." She sounds like an interesting lady, but Mrs. Mason is also dying of AIDS.

She was infected from a transfusion she received during the birth of her second child. Two years ago, the president named her to the National Commission on AIDS. She recently wrote to the president to explain, "The blanket screening of health care workers will create the false illusion that people with AIDS are a threat to others ... Doctors don't give people AIDS -- they care for people with it."

AMA President Dr. John Ring emphasizes one of the factors of professionalism during his speech at the First Session of the House of Delegates.

She is so right. The only known case of transmission from a health care worker to patients is the case of Dr. David Acer in Florida, and no one can quite figure out how he did it. So far, there is no firm evidence of any doctor-to-patient transmission of AIDS.

Our medical profession has been on the compassionate forefront of dealing with AIDS. For instance, the AMA spoke out early and with great courage, reminding doctors all across America of their ethical obligation to care for those who are struck down by this dreadful disease. Early this year, the AMA board went on record urging infected doctors not to perform invasive procedures that pose an "identifiable risk" to patients, without getting patients' consent.

This policy puts the patient first, and that's as it should be. At our annual meeting in June, AMA delegates called for "appropriate" HIV testing of physicians and, at the same time, urged easing consent requirements that govern patient testing. You are probably also aware that last month, the Centers for Disease Control endorsed limited restrictions on the practices of HIV-infected health care workers and re-emphasized the importance of universal precautions.

Much as we do, CDC urges that those testing positive for HIV to stop performing invasive procedures.

The HIV-testing question will probably continue to attract a great deal of public attention, some public hysteria and much public misunderstanding. Nevertheless, we must continue to deal with it in the context of the doctor-patient relationship. The AIDS epidemic is tragic indeed. Yet, it is a powerful test of our professionalism. I believe we are equal to the test if we keep our professional attention on the patients we serve.

With that, let's turn to my second topic -- physician payment reform. I know you've been keeping up-to-date about the resource-based relative value scale in *WESGRAM* and *West Virginia Medical Journal*. I know you are aware that Senator Rockefeller wrote to Secretary Louis Sullivan to protest the negative impact that the administration's implementation plan can have on Medicare. I know you have heard that Senator Rockefeller has also let Gail Wilensky know how he feels about her agency's attempts to use RBRVS as a budget-control device. In addition, because you practice in the state with the second lowest Medicaid reimbursement rate in the nation, I know I don't need to explain to you why we are so worried at the prospect that Medicare reimbursement might fall even lower than Medicaid!

When we look at RBRVS in the context of the doctor-patient relationship, we know we must continue to fight for the principles on which it is based and to fight against its misuse. This is not just a "pocket-book issue." We are on the moral high ground here. Just last week, the *Washington Post* declared, "The AMA is right on this one and the system is too valuable to let the bureaucracy produce a result that no one intended" (1).

I believe it is a mark of our professionalism that medicine has been working together for several years to back RBRVS as a way to bring fairness and equity into a system that we all recognize needs those qualities for the good of our patients. It is a tribute to our professionalism that medicine is now mounting an aggressive campaign to make sure that the RBRVS begins as it was intended. We are doing this for our patients. It's their reimbursement that's being cut. In trying to use RBRVS to cut its budget, HCFA threatens their access to medical care, which we must not allow!

This brings me to my third topic -- access to care. In May, a *JAMA* special issue on "Caring for the Uninsured and Underinsured" announced, "It is no longer acceptable -- morally, ethically or economically -- for so many of our people to be medically uninsured or seriously underinsured." *JAMA* also stated, "We can solve this problem" (2).

And problem it is! More than 30 million of our fellow citizens are suffering the effects of a total lack of health insurance. Our profession is responsible for their medical care.

I know that when Dr. Tupper visited you last year, he talked about the AMA's Health Access America proposal. He described it as a "call to conscience among medical professionals," and that is just what it is. Health Access America has proven to be a powerful tool to bring access higher in the public debate.

For example, I understand that during your 1991 legislative session, West Virginia passed a small business health insurance program along the lines of our program. Around the nation, in fact, Health Access America is a wonderful success because organizations such as the West Virginia State Medical Association are getting behind it with spirit, realism and energy.

Physicians must take the lead on access to care. It is, indeed, the right thing to do. Our profession has done the right thing in many instances. Still, we have other, more transcendental problems facing us.

In a groundbreaking *JAMA* article, Dr. David Hilfiker wrote, "Medicine is quickly changing from a servant profession into a business and it is the poor who are most deeply affected" (3). Eli Ginzburg was the author of an article in the *New England Journal of Medicine* entitled, "The Monetarization of Medicine," indicating that medical practice in the United States has become monetarized (4). Emily Friedman stated in *JAMA* that the medical profession regards the poor as "somebody else's problem" (5). In addition, a special communication appeared in *JAMA* itself entitled, "The Deprofessionalism of Medicine" (6).

If these articles contain a fraction of truth, then access is a symbol. The uninsured are the tip of the iceberg and we are the real issue.

Are we a profession to which business interest is incidental, or are we a business to which our professionalism is incidental?

Are we entrepreneurs or servants?

Are we providers or healers?

Are we vendors or care-givers?

What we are now, and in the future, is up to us. My friends, if we choose to save our professionalism, it will mean sacrifices on our part -- real, personal sacrifices. Yet, it is certain that if we, willingly, sacrifice for the good of our patients, we gain in public esteem, we gain in self-respect, we gain in the power of our professionalism to do our best for our patients.

This is what it is to be a doctor -- and this is what it always must be.

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Thomas L. Harris Address

Annual Meeting 1991

The Physician's Role as a Community Leader: Being More Than Just Good

JOHN M. TEW JR., M.D.
Professor and Chairman, Department of Neurosurgery
University of Cincinnati Medical Center, Cincinnati

The opportunity to address the West Virginia State Medical Association brings a special sense of pleasure because we share many common bonds as colleagues from sister states. First, we share a mutual respect and admiration for your president-elect, Dr. Constantino Amores, a neurosurgical brother, an internationally recognized surgeon, a community leader and, more importantly, a colleague deeply involved with his fellow men and women.

Second, we share respect for a heritage that dates back 14,000 years when Indians entered the Ohio and Kanawha valleys. The area that became West Virginia remained hunting and battle grounds until Europeans arrived in the 1700s. The independent spirit of these settlers of Western Virginia was reflected when they defied Virginia's secession convention of 1861, elected to remain within the Federal Union, and eventually formed a new state. Their spirit is symbolized by the motto of West Virginia, "Montani Semper Liberi" (Mountaineers Always Free). The rugged land engendered early isolation and resulted in a strong, self-reliant local heritage, largely unaffected by circumstances beyond these wild and wonderful hills. This heritage persists today, but in a spirit enhanced by a vitality that reaches for new horizons in economic productivity, education, transportation, and health and welfare.

Third, since this address was inaugurated in 1973, we have honored Dr. Thomas L. Harris, a renowned surgeon from Parkersburg. He held sacred the qualities of stewardship, leadership and responsibility to profession and community. Dr. Harris generously supported civic programs and education for the underprivileged. Past addresses by distinguished leaders in the American medical profession included important issues such as the future of American medicine, current trends for evaluating the quality of medical care, medical education, and the physician in politics. These subjects commanded interest and certainly deserved our focused attention.

Renown neurosurgeon Dr. John M. Tew Jr. stresses a point as he delivers the Thomas L. Harris Address.

The Physician's Role as Citizen

This year, the program committee requested an address about the physician's role as a citizen. In selecting a title, I chose a concept from Dr. Harris' address at the WVSMA's Annual Meeting in 1945. He reflected on providing care for those who have borne the battle in the greatest cause in human history (World War II). Dr. Harris reminded the WVSMA to be more than just good.

He recognized the achievements of those who made breakthrough discoveries but, more importantly, he focused on ordinary people, like most of us, called to become more than just good doctors. He challenged us with a message that is even more appropriate today,

"Become so good at something interesting and creative that other people are glad to have us around; be good at finding more work that needs to be done; discover opportunities that most people overlook and think of things to do that other people forget. This is the way to be a creator, to help something original and unexpected to occur." He admonished us that we are born to enrich the lives of others.

Dr. Harris advised his fellow physicians to fulfill a prime purpose of service to humanity by helping others to live, be healthy, and create a shareable life for each other. These guidelines formed the basis for the doctors' philosophy. I believe that history documents Dr. Harris as a strong and energetic man from whose body flowed tremendous energy, and free and forthright speech. He was widely recognized and respected for his integrity and trust.

A Call for Greater Involvement

The special privileges and knowledge that come with doctoring should help us understand that the problems of health and medical care of our society deserve our attention. Like Dr. Harris, I strongly believe that changes in our world in general, and in medicine particularly, call for greater social involvement in a broader and more integral role than ever before expected of our profession.

A profession may be defined as a group composed of highly-trained individuals who possess a unique body of knowledge and a call, a ministry. In fact, medicine originates from the priesthood with professional roots deeply tapped in healing physical and spiritual ills. This calling, our profession, derives power from the value that society assigns our work. A profession sets its standards and is responsible for policing its members. Until recently, society gave the medical profession extraordinary freedom, primarily because it believed the profession had an unequivocal commitment to put individual interest and public health needs ahead of personal gain. Our oath affirms that we hold no proprietary knowledge. Our knowledge is not individually owned but held in trust for the good of the sick and the promotion of health for society. Those professing a career in medicine become part of a collective covenant that must be interpreted in the sense of improving the community welfare. Aesculapius admonished, "Carry forth the noble work -- make it better than you found it and then hand it on to posterity."

Medicine has thrived on the advances in the highly physical and biological sciences, especially as the technical progress of the past hundred years was applied to caring for patients. While we physicians enjoy the benefits of the scientific revolution in healing the body, simultaneously, we suffer from a gradual erosion of our personal identity as healer. We react to the criticisms that we have become self-serving and economically driven. Frequently, such criticisms are directed at the health system in general. Many offer healthcare reform schemes -- indeed, the idea of reform has taken an aura of inevitability. Most proposals coming from physician groups, health policy analysts, think tanks, employer coalitions and legislators involve more self interest than reform. Critics claim that the health systems are too big, too hospital-oriented, too expensive, not cost-effective, poorly distributed and too impersonal. While many criticisms are not aimed at doctors, we are increasingly accused of being arrogant, uncaring, selfish, greedy and disinterested. Gradually, the rising tide of consumerism has transformed medicine into a product or service that government and other institutions deliver for ever-increasing costs.

The Seed of Greatness Within

Literally, our profession hangs in balance. The time is critical, but it can be our time if we act rather than react. This can be our time if we endorse service and volunteerism, if we rise to the moment and provide clear leadership. We must refocus on our mission to comfort, care and provide hope. We must remember the secret of providing good care for the patient is caring. Both our needs and those of our patients are security, trust, intimacy and hope. We must be sensitive to these human needs. Patients invite their doctors to combine the role of priest, philosopher, poet and scholar. Patients expect their doctors to evaluate their lives as biographers or to act as guides in a foreign land.

While patients need an environment more like home and less clinical, our institutions have become too sterile. Though every patient cannot be saved, we can respond and, in doing so, we may save ourselves through the rewards of service. Service will help us to regain our balance. A balanced person acknowledges that the rewards of service provide greater satisfaction than the effort required. Good works have redeeming value, value expressed in the satisfaction of knowing that we can help to meet the needs of others.

Every physician carries within the seed of greatness, regardless of how ordinary the life, work or dream. The release of this seed is not guaranteed. Release directly relates to, and surely depends on, expressing our sensitivity, that is, the freedom to choose service-oriented behaviors. Although ethics in the school curriculum, seminars on humanism and public discourse are helpful, the final decision to act must come from internal commitment. Commitment springs forth when we let down our barriers and establish renewed relationships that we can share. A renewed relationship with our patients will allow us to share wonder, trust and hope, as well as fear and exaltation on the edge of life, between the natural and supernatural.

This crisis can be our turning point if we physicians become models for change. We can provide leadership among all professions that will rekindle the flame of respect for right behavior. While I do not plea for physicians to campaign for political office, I do remember that Pericles said, "We do not say that a man who takes no interest in politics minds his own business. We say he has no business here at all."

Physicians must become involved in community affairs and activities. We must participate in civic councils both for artistic and cultural enlightenment of the community, or in other activities where our

influence will improve the quality of life for our neighbors. Darwin and others long since discovered that losing appreciation for literature and the arts threatened the mind with degeneration into a kind of machine, suited only for grinding. Or, as Goerte wrote more beautifully, "A human should hear a little music, read a little poetry, and see a fine picture every day of life in order that the wordly cares should not obliterate the sense of beauty that God has implanted in the human soul."

Developing Leadership and Mature Ambition

In all philosophical discussions, we embrace a systematic belief system, whether we call it faith or philosophy, or their combination religion. Physicians must develop a rational process to provide sustenance in the most difficult crisis. Similarly, our patients need to know that their doctors will honor their faith, regardless of its diversity. Patients need to know that we acknowledge a higher power and that we understand the Scriptures in the broadcast cultural context, particularly by expanding our Western interpretation of the Scriptures. In this vein, ministers and physicians are expected to concern themselves with all who need help and hope, including the most repugnant. Indeed, throughout this gospel, Luke (the patron saint of physicians), showed concern for those less favored by society, balanced male and female characters in his stories, healed physical ailments and addressed social inequities. He quoted, "He who would be chief, first let him be servant (Luke 22-26)."

Practicing servant leadership does not mean that we should cast aside personal ambitions and career goals. But, ambition is healthy only when worthwhile goals are achieved, not at the expense of others but with their help. Ambition is mature, not when we know what we want and how to get it, but when we understand what we possess and how to give it.

As a servant leader, Jesus lowered himself to wash the feet of his disciples — a menial task that gained him additional respect and loyalty. Through concern for others, we can make the greatest contribution to our community and enhance the success of our profession. Of course, even if we could follow Jesus' example, we would encounter obstacles at many points. Jesus faced betrayal and denial in critical moments. We are operating in an imperfect world, but we can make a difference. The world will be a better place when we become better people.

In closing, I thank each of you for the opportunity to share my opinions and hopes with you. It is time to review our lives and make adjustments, to balance the focus ensuring that we will be better than good, and to ensure that we will leave a legacy of trust, love, and hope for our children who will bear our profession and community into the 21st century. "He who has the torches will pass them to others (Plato, Republic)."

Farewell Address

(Continued from page 447)

message such as the second Executive Committee retreat the first of June. Just a few of the 66 issues addressed at that retreat were:

1) Communications with increased use of *Wesgram* inserts and in-house printing.
2) Continued mailing of the *West Virginia Medical Journal* to our state and national legislators.
3) The West Virginia Medical Care Foundation — a non-profit foundation.
4) Enhanced internal office organization and flow.
5) Membership development and new physician tracking, including membership packets and physician recognition.
6) Socioeconomic issues.
7) Alliances and coalitions.
8) Continuing the very successful *White Paper* and patient brochure.

I hope this long recitation of some of your president's adventures of the past year has illustrated the saying, "A president is what a president does."

In conclusion, I should like to say that my wife and I have visited every county medical society to which we were invited. We were always received with the most gracious friendship and hospitality. We thoroughly enjoyed each and every meeting and the comradeship that we found.

Thank you very much. You have been good friends.

Photo Highlights

Annual Meeting 1991

Psychiatrist Dr. Ahmed D. Faheem expresses his appreciation after receiving the Wyeth-Ayerst Physician's Recognition Award for the numerous service contributions he has made to the Beckley community, especially his telephone hotline network for troubled teenagers.

New WVSMA President Dr. Constantino Amores and his family celebrated his inauguration at the reception honoring the new officers of the WVSMA and Auxiliary. Pictured from left to right are his daughter, Ange; his son, Christopher; his wife, Diana, with grandson, John Walsh Jr.; Dr. Amores; his son, Constantino Jr., and his wife Janet, who is holding their son, Constantino III; his son-in-law, John Walsh and his wife, Annabelle.

Phil Benson, a reporter for WOWK-TV, is congratulated by Dr. Joseph Touma, president of the Cabell County Medical Society, for being awarded the WVSMA's Presidential Citation for professional contributions to healthcare in West Virginia. Dr. Touma nominated Mr. Benson for "continuously reporting on health issues for eight years and helping citizens of the Tri-State area improve their diet, health and quality of life."

Dr. R.W. Coplin, the first recipient of the WVSMA's newly-created Rural Health Care Award, shakes hands with Dr. Michael Stump, WVSMA 1990-91 president, as he is presented with his plaque. Standing beside Dr. Coplin is Dr. Bill Atkinson, WVSMA 1988-89 president, who nominated "Dr. Bob" for the award because of his outstanding dedication to the residents of Wirt County.

Dr. Thomas Chang of Clarksburg moderated the Second General Session entitled "Update on Cancer Management 1991."

Some of the new members of the Executive Committee posed for a group portrait at the reception which was held in their honor. Pictured from left to right are Drs. Derrick Latos, councilor-at-large; Michael Stump, Council chairman; Constantino Amores, president; Robert Pulliam, president-elect; and James Comerci, vice president. Not present for the picture were Drs. William Morgan, treasurer; and Bill Atkinson, junior councilor.

Delegate Tom Susman (D-Raleigh) and Senator Joe Martin III (D-Marion) discussed the proposed Physicians' Medicaid Enhancement Plan with members of the WVSMA's House of Delegates prior to the House's vote on this subject.

Dr. John Markey, who was elected the new AMA delegate, took the microphone during the First Session of the House of Delegates to speak about his candidacy.

Joseph Schock of the Office of Environmental Health Services of West Virginia shows slides during his presentation entitled "Environmental Health — The Infectious Medical Waste Act," which was part of the panel discussion on "Regulators' Recipe for Patient Care." Moderator Dr. Stephen Sebert and the other panelists, Dr. Eileen Catterson and Dr. Harry Weeks, are pictured in the background.

Kevin Kaufman, secretary-treasurer of the WVU Medical Student Section (Morgantown) of the WVSMA, addressed the House of Delegates during their Second Session.

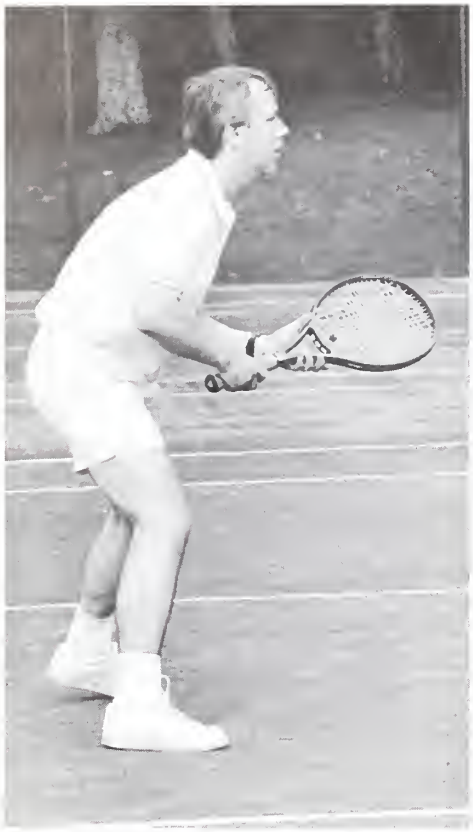
Dr. Harry Weeks was recognized by the House of Delegates with a standing ovation for his many years of service as an AMA delegate.

Pat Clark, AMA director of media relations, conducted a stimulating "Meet the Media" workshop to teach physicians and their spouses how to communicate with reporters more effectively.

Dr. Stephen Ward, editor of the *West Virginia Medical Journal,* and five of the seven associate editors, (seated) Drs. Joe Jarrett and Harvey Reisenweber, and (standing) Drs. David Morgan, John Hartman and Robert Marshall, attended the Publication Committee meeting during the convention.

Delegate Rick Staton (D-Wyoming) discussed the Legislature's plans for redistricting at the WESPAC meeting. Talking with Delegate Staton are Delegate Nancy Kessel (D-Kanawha), Delegate Barbara Sims (R-Wood), WVSMA President-Elect Dr. Robert Pulliam, and WESPAC Treasurer Dr. Alva Deardorff.

Dr. Albert Esposito of Huntington was one of the 14 past presidents presented with a silver medallion by Dr. Michael Stump, WVSMA 1990-91 president, in honor of their contributions to the WVSMA.



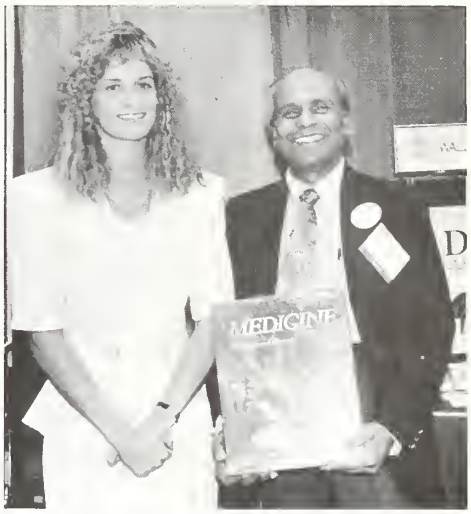
Dr. Tim Brown of Weirton awaits a serve during a match in the men's tennis tournament.

The team winners of this year's golf tournament were Dr. Manuel Franco, Jim Adkins, Tom Keeney, Robert Kidd and Dr. Estelito Santos.

Dr. Roger Ray of Anderson, S.C., was the winner of the trophy for low gross in the golf tournament.

Members of the winning volleyball team, Drs. James Comerci, Diane Shafer, Dan Wilson and John Holloway, were presented with bottles of champagne. Other team members who were not present for the picture were Drs. Harry Reisenweber and Dennis Burech.

Rhonda Kneafsey and Bob Meinert of SmithKline Beecham Pharmaceuticals talk with physicians at their exhibit booth.



Dr. Murty Bellam of Man happily poses with Theresa Artip, sales representative for Wallace Laboratories, after winning the book "Medicine: An Illustrated History," which her company gave as a door prize.

Dr. William Neal was the lucky winner of a gift certificate in the door prize drawing. WVSMA staff members Teresa Crouch and Cindy Hagerman assisted Dr. James Comerci, the new WVSMA vice president, with the door prize presentations.

Exhibitor Jan Fox of the Marshall University School of Medicine demonstrates the school's new computer data system.

Auxilians Trudy Tordilla, Judy Bofill and Siromani Bellam created an attractive display for the WVSMA Auxiliary's exhibit.

New Auxiliary President Janie Altmeyer (far right) and her officers, Judy Bofill, Southwest regional director; Ginny Reisenweber, treasurer; Carole Scaring, recording secretary; Barbara Sims, vice president; and Pacita Salon, president-elect, assembled for a group portrait at the President's Luncheon during the WVSMA Auxiliary's Convention.

Sherry Strebel, president of the AMA Auxiliary, delivered the keynote address at the WVSMAA convention.

Sara Townsend, WVSMAA 1990-91 president, and her husband, Dr. Vincent Townsend, were a dashing couple at the WVSMA Presidential Reception.

Sara Townsend, WVSMAA 1990-91 president, conducts the proceedings as the auxilians select candidates for the Nominating Committee.

Auxilians enjoy playing in the bridge tournament.

1991 Resolutions

Resolutions 1 and 19

WHEREAS, the quality of peer review is dependent on physician participation, and

WHEREAS, the Peer Review Organization is supposed to be a mechanism to insure quality of medical care, and

WHEREAS, there have been some significant problems in the way physicians view this organization, therefore be it

RESOLVED, that the West Virginia State Medical Association request the PRO to work together and formulate a report regarding the following functions:

1) that the reviewers be properly credentialed;
2) that physicians are reviewed by a physician in their specialty;
3) that the criteria used to review charts are periodically updated;
4) that the physician reviewer should have to identify himself to the practitioner whose case is in point therefore be it

RESOLVED, that the WVSMA work with the PRO to obtain the Medicare carrier screens used in the review process and be it further

RESOLVED, that the PRO provide examples of adverse effects on patients and identify where these events are avoidable, and be it further

RESOLVED, that the WVSMA encourage physician participation in the PRO.

Resolution 2

WHEREAS, the Preferred Provider Organizations for cataract surgery for New York, Ohio and Texas are being solicited by the Health Care Financing Administration to offer services to Medicare patients at lower fees and inducing patients by waiving current, mandated Medicare deductibles and co-payments, will unnecessarily compromise the community-based nature of cataract surgery, and

WHEREAS, the American Medical Association has addressed this issue in Resolution 141, A-91, therefore be it

RESOLVED, that the WVSMA endorse AMA Resolution 141 calling for the AMA to (1) take appropriate steps to prohibit the expenditure of federal funds for the development and implementation of the Medicare preferred provider organization type demonstration project for cataract surgery to be conducted by the HCFA, (2) oppose any similar demonstration projects taking place in any community, regardless of the type of medical/surgical services involved, and (3) forward to appropriate members of Congress its objections to the Medicare cataract surgery demonstration projects.

Resolution 3

WHEREAS, health care workers, including physicians, and health care facilities are increasingly threatened by the increasing frequency and higher settlements in medical malpractice cases, therefore be it

RESOLVED that the WVSMA, through every means available, continue to seek endorsement and support of West Virginia's U.S. senators and representatives for the Access to Health Care Through Tort Reform Acts that have been submitted in both the Senate and the House.

Resolution 4

WHEREAS, the medical profession is increasingly threatened by jury settlements of medical malpractice cases above insurance limits, therefore be it

RESOLVED that the WVSMA continue to seek the support and enactment of legislation and a constitutional amendment in West Virginia for protection of "homestead" in such cases.

Resolution 5

WHEREAS, the medical profession is beset by the increasing hostile medical environment in West Virginia, and

WHEREAS, medical malpractice liability is a part of general and product liability in the United States, therefore be it

RESOLVED, that the WVSMA continue to contact other professional and business organizations to seek reform of legislation as it relates to general, product and medical liability.

Resolutions 6 and 7

WHEREAS, non-use of seat belts and motorcycle helmets results in inordinate injury and subsequent hospitalization and treatments, therefore be it

RESOLVED, that the WVSMA seek endorsement and support by West Virginia's U.S. senators and representatives for appropriate federal legislation mandating the use of seat belts and motorcycle helmets.

**National Highway Fatality and Injury Reduction Act, HB-1782*

Resolutions 8, 23 and 24

WHEREAS, excessive injury and death to children riding in the back of open trucks occurs and

WHEREAS, the AMA has already addressed this issue in Resolution 15, therefore be it

RESOLVED, that the WVSMA, seek the endorsement and support by West Virginia's U.S. senators and representatives for any appropriate proposed federal legislation banning the transportation of children in the back of trucks and introduce and support AMA's proposed model state legislation prohibiting the transportation of children in the back of trucks.

Resolutions 9 and 10

WHEREAS, the vast majority of sales from cigarette vending machines is to minors, therefore be it

RESOLVED, that the WVSMA seek the endorsement and support by West Virginia's U.S. senators and representatives for any appropriate proposed federal legislation banning cigarette vending machines and banning smoking in all public areas and buildings (government buildings, state capitol, restaurants, etc.).

Resolution 11

WHEREAS, the Healthy West Virginia Coalition has been developed to coordinate health promotion and the wellness initiative in West Virginia, and

WHEREAS, the WVSMA was instrumental in the formation of the Healthy West Virginia Coalition, and

WHEREAS, the WVSMA is the coordinator for health care providers in the Healthy West Virginia Coalition, therefore be it

RESOLVED, that each component society of the WVSMA be encouraged to identify a member to coordinate the activities of the Healthy West Virginia Coalition in each respective area, and be it further

RESOLVED, that all members of the WVSMA be encouraged to enthusiastically support the activities of the Healthy West Virginia Coalition.

Resolution 12

WHEREAS, The Phillip Morris Company, Inc. is sponsoring the nationwide tour of Virginia's original copy of the Bill of Rights, and

WHEREAS, The Phillip Morris company is a major manufacturer of tobacco products and promotes the use of tobacco, and

WHEREAS, The Phillip Morris Company appears to be attempting to link the Bill of Rights to smoker's rights, and

WHEREAS, on its nationwide tour The Phillip Morris Company is recruiting local civic, business and veteran's organizations and particularly schools and children's organizations to serve on their host committee, and

WHEREAS, The Phillip Morris Company's sponsored Bill of Rights tour will be at the Charleston Civic Center November 27-December 1, 1991, and

WHEREAS, tobacco abuse is one of the major causes for the poor health suffered by many West Virginians, and

WHEREAS, the AMA has already addressed this issue in Resolution 9, therefore be it

RESOLVED, that in accordance with the AMA's Resolution, No. 97, the WVSMA take actions to counteract the tactic of The Phillip Morris Company to promote the use of tobacco products with the Bill of Rights.

Resolution 13

WHEREAS, Waste Technologies Industries (WTI) is building the nation's largest hazardous and toxic waste incinerator on the Ohio River bordering West Virginia, and

WHEREAS, the WTI toxic waste incinerator poses a serious threat to the health environment of northern West Virginia and the entire Ohio River Valley, therefore be it

RESOLVED, that the WVSMA oppose the incineration and disposal of toxic waste by the WTI plant in Ohio and, be it further

RESOLVED, that the WVSMA support the efforts of the governor, attorney general and Legislature of the state of West Virginia in their efforts to prevent the start of operations of the WTI toxic waste incinerator.

Resolution 14

WHEREAS, OBRA 90 instituted in January 1991 gave specific Medicare fee reductions for "new physicians" of 80% payment to all physicians in their first full calendar year of medical practice (equally discounting payments during the months practiced prior to the first of January), and of 85%, 90% and 95% to all physicians in their second, third, and fourth calendar years of practice respectively, and

WHEREAS, even after RBRVS implementation begins in 1992, these payment differentials will persist in law, and

WHEREAS, the AMA Council on Legislation has placed the elimination of this discriminatory policy as its number one legislative priority, and

WHEREAS, Congressman Edolphus (Ed) Towns (D-NY) has introduced HB-1898 to repeal Medicare payment differentials for "new physicians", and

WHEREAS, it is critical for each state and specialty society in the federation to join the AMA in the upcoming battle to ensure equitable payments for all physicians under RBRVS, therefore be it

RESOLVED, that the WVSMA strongly oppose the onerous provisions of OBRA 1990; which currently discriminate in payments to new physicians, and be it further

RESOLVED, that the WVSMA establish the elimination of payment differentials for new physicians as a top ranked legislative priority for 1991 and beyond, if necessary, with the commitment of appropriate staff resources and key contacts, and be it further

RESOLVED, that the WVSMA persistently encourage its congressional delegation to co-sponsor HB-1898 and its companion Senate bill when introduced.

Resolution 15

WHEREAS, the annual business meetings of the WVSMA are becoming increasingly more important, therefore be it

RESOLVED, that the president appoint an ad hoc committee to study all facets of the Annual Meeting.

Resolution 16

WHEREAS, over 50,000 head injuries to children occurred last year on bicycles, and

WHEREAS, over 85% of these injuries could be reduced or eliminated with bicycle helmets, and

WHEREAS, the American Academy of Pediatrics has developed a program to distribute bicycle helmets at a markedly reduced rate through physicians' offices, therefore be it

RESOLVED, that the WVSMA promote the American Academy of Pediatrics' program to distribute bicycle helmets at reduced rates through physicians' offices, and be it further

RESOLVED, that distribution of this information be given to the component societies throughout the state.

Resolution 17

WHEREAS, West Virginia has three medical schools; West Virginia University Medical School, Marshall University Medical School and the West Virginia School of Osteopathy at Lewisburg and many states our size have only one medical school, and

WHEREAS, several commission studies of the West Virginia medical education system have recommended that West Virginia does not need more than one medical school, and

WHEREAS, West Virginia's need for wise use of its dollar is obvious to all, and

WHEREAS, there have been tremendous tensions on the medical education system in the past year in the medical education community and a diversion of tremendous talents toward this political process instead of their assigned function, and

WHEREAS, the WVSMA not taking a stand on medical education is even more detrimental to the medical education and medical cooperation than taking a specific stand on an over-all state plan, therefore be it

RESOLVED, that the WVSMA's Committee on Medical Education make specific recommendations relative to medical education in West Virginia and submit a report to the Executive Committee no later than the November 10 Council Meeting of the Association.

Resolution 18

WHEREAS, there are separate Boards of Medicine and Osteopathy in the state of West Virginia, and

WHEREAS, the practicing conditions of osteopaths and allopaths are very similar and frequently side by side in the institutions throughout the state, and

WHEREAS, physician assistants' regulations have been combined in the past with the State Board of Medicine, therefore be it

RESOLVED, that the WVSMA request the state of West Virginia to combine the Boards of Osteopathy and Medicine to provide a more consistent function and to promote the cooperation of these two disciplines.

Resolution 20

WHEREAS, the future of medicine in West Virginia and in the nation is in the hands of the elected state and federal representatives, and

WHEREAS, the level of contributions by WESPAC, the West Virginia Medical Political Action Committee, in the 1990 state election campaigns was some $31,000, in comparison to the teachers' political action committee which contributed over $102,000, and

WHEREAS, every physician should become a member of WESPAC/AMPAC, our state and AMA political action committees, and WHEREAS, the leadership of the WVSMA which includes the Executive Committee, Council and the members of the House of Delegates, should set the example for membership and join WESPAC/AMPAC in carrying out their duties, and therefore be it

RESOLVED, that WVSMA leadership as identified above shall be urged to join WESPAC/AMPAC at any of the three levels of membership (i.e. Regular $50, Sustainer $100, or Extra Miler $150).

Resolution 21

WHEREAS, West Virginia currently has three medical schools and various outlying residency programs, and

WHEREAS, many of these residents, who in particular are native West Virginians, leave their state upon graduation, and

WHEREAS, many rural West Virginia localities are poorly staffed by physicians or not staffed at all, and

WHEREAS, many of our West Virginia citizens have poor access to proper medical care due to financial considerations or long distances that must be traveled to reach medical care, and

WHEREAS, there may be many methods to achieve this goal such as:

1) state funded grants for aid in establishing a medical practice in rural West Virginia localities;
2) grants and incentives through private enterprise;
3) increased reimbursement and more timely payment from Medicaid and state insurance;
4) state funded and supported clinics with physicians on salary with incentives in rural localities;
5) contracting physicians to work in rural localities and then assume private practice after a number of years; and
6) state funded financial aid or scholarships for medical students and residents in a contract agreement to practice in West Virginia, therefore be it

RESOLVED, that the WVSMA's Committee on Medical Education make recommendations on ways and means that would stimulate graduating residents of the West Virginia medical school system to establish their medical practices and remain in the state and report such recommendations to the Executive Committee no later than January 1, 1992, and be it further

RESOLVED, that a method be established for tracking WV citizens in out-of-state medical school residency programs and that a method be established for recruiting these physicians.

Resolution 25

WHEREAS, there are currently several insurance companies offering malpractice coverage to the physicians of West Virginia and

WHEREAS, these physicians have no means of judging the financial stability of these companies and

WHEREAS, there is widespread concern about the financial stability and long range survivability of all insurance companies and financial institutions, therefore be it

RESOLVED, that the WVSMA request the Insurance Commissioner of the state of West Virginia release to the WVSMA the rating reports, financial statements and supporting documents of the insurance companies offering malpractice coverage in this state, and his analysis of these reports to enable the WVSMA to advise its members on the purchase of their coverage.

These motions made by Dr. Bryant were also approved:

The WVSMA has been losing members, and a large percentage of West Virginia physicians do not (but should) belong to WVSMA. Organized medicine must have a strong voice in developing health care policy, and a larger membership will mean a stronger, more representative WVSMA.

Therefore, I move that the WVSMA develop and carry out a grass roots campaign to recruit all West Virginia physicians into its membership.

The current RBRVS conversion factor is reduced for payment to West Virginia physicians, and the work factor is reduced for West Virginia physicians but in reality, West Virginia physicians work as much as any other physician in caring for their patients. The risk (liability) factor is reduced for West Virginia physicians but the liability cost in reality is higher for West Virginia physicians, and such negative discrimination has and will continue to deter physicians from practicing in West Virginia.

West Virginia physicians are already paid less than the national average, therefore, I move that the WVSMA seek appropriate corrective modifications in the RBRVS conversion factor through our U.S. senators and representatives.

Annual Reports

Committee on Cancer

Meetings of the Committee on Cancer were held August 17, 1990, during the West Virginia State Medical Association Annual Meeting at The Greenbrier in White Sulphur Springs; and during the Mid-Winter Clinical Conference on January 27, 1991, at the Charleston House Holiday Inn in Charleston.

Kathleen Carey from the Bureau of Public Health of the West Virginia Department of Health and Human Resources, reported that the proposed grant from the National Cancer Institute concerning a 7-year data based research study was not funded.

Ms. Carey also reported on the House concurrent resolution which requested that the Joint Committee on Government and Finance, in cooperation with the Bureau of Public Health, study the feasibility of establishing a statewide cancer registry. This project was fully endorsed by the Committee on Cancer.

The committee gave its support of the proposed grant by Jane Morley Kotchen, M.D., M.P.H., to the NCI which involves a joint venture by the WVSMA and West Virginia University. The grant involves the efforts of the primary care physicians in screening for breast, cervix, oral and colorectal cancers.

Dr. William T. Wallace Jr., M.P.H., commissioner of the West Virginia Bureau of Public Health, and Helen Fisher, R.N., director of Womens' Services for Maternal and Child Health of the West Virginia Bureau of Public Health, announced the Bureau of Public Health was the recipient of a $2.5 million grant — Public Law 101-354, Title XV (Preventive Health Measures with Respect to Breast and Cervical Cancer.) The grant is to cover a three-year period and will involve indigent and low income women.

The review process for the purpose of carrying out the programs include the following:

(1) screening women for breast and cervical cancer as a preventive health measure;

(2) providing appropriate referrals for follow-up services;

(3) developing and disseminating public information and education programs for the detection and control of breast and cervical cancer;

(4) improving the education, training and skills of health care professionals in the detection and control of breast and cervical cancer;

(5) establishing mechanisms through which the state can monitor the quality of screening procedures to include interpretation of such procedures; and

(6) evaluating activities through appropriate surveillance or monitoring.

The program was endorsed by the committee and it was suggested that this information be published in *WESGRAM* and the *West Virginia Medical Journal.* Those individuals interested in participating in the program were asked to contact Helen H. Fisher, R.N., at 348-5388 or 1-800-642-8522.

Loretta Haddy, epidemiologist for the West Virginia Department of Health, presented a proposal for a bill to establish a Cancer Registry with the approval of the American Cancer Society and the Department of Health. The committee also approved supporting this project.

Dr. Raich announced the details for Cancer Awareness Day which was presented with the American Cancer Society on February 13. He also gave an update on the Mary Babb Randolph Cancer Center's research activities and the PDQ Information Center.

Mrs. Covey reported that the PDQ system is available for information on state-of-the-art treatment of cancer.

The committee recommended the following information be published in *WESGRAM.*

1. PDQ and mammography A.C.R. certification facilities.
2. The Oncology Spring Meeting at WVU.
3. Recommendations for hospitals and health care facilities to be SMOKE FREE.
4. The Committee on Cancer's next meeting.

Catalino B. Mendoza, Jr., M.D., F.A.C.S.
Chairman

Committee on Legislation

The WVSMA Committee on Legislation met monthly over the spring and summer months of 1991. As a result of those meetings and the work of four subcommittees, the 1992 Legislative Priorities were developed and submitted to the Executive Committee and Council at the annual meeting. The committee further recommended the adoption by the WVSMA House of Delegates of the Physicians' Medicaid Enhancement Plan developed by a special interim committee of the West Virginia Legislature.

The four subcommittees undertook areas of study in expanding the scope of practice for nurse practitioners and nurse midwives, rural health care, reimbursement issues and tort reform. Further, the committee sought information and research regarding the funding mechanisms of free clinics and rural health care centers from consultants Perry & Haid.

The committee also reviewed three controversial issues -- mandatory HIV testing of physicians, pharmacists prescribing, and single payor/universal health care

coverage. The committee agreed to later develop WVSMA position papers on these issues.

The following legislative agenda was submitted to WVSMA Council and subsequently adopted at the August meeting of Council:

* Tort reform legislation that includes structured settlements of awards over $100,000; collateral source offset; $200,000 cap on non-economic damages; reducing statute of limitations to a total of six years and two years after discovery; meritorious claim screening; frivolous claim filing penalties; homestead exemption for all West Virginians; and a ban on tort balance billing above liability policy limits.
* PEIA reforms which establish a reasonable and fair reimbursement schedule, provide adequate funding for the program, and add physician representation to the PEIA Finance Board and prompt payment of claims.
* Blue Cross/Blue Shield legislation to address the debt left by the firm to spread the losses among physicians, hospitals, other health care providers, employers, beneficiaries and the Blue Cross Mountain State Plan. Further, the legislation should provide state tax credits to physicians with BC/BS debts to write off.
* Uninsured, underinsured, uninsurable and Medicaid care issues to be addressed in legislation calling for adoption of the AMA Health Access America Plan, correcting misappropriation of Medicaid funds, adopting the Physicians' Medicaid Enhancement Plan and prompt payment of claims.
* Workers Compensation Fund legislation to radically restructure the plan to include incentives to minimize injuries, identify and eliminate providers and beneficiaries that abuse the system, reduce paperwork, provide rapid and fair provider payment and fair settlements with injured workers, and mandate use of the HCFA-1500 forms for processing claims.

The Subcommittee on Nurse Practitioners and Midwives, chaired by Richard S. Kerr, M.D., recommended that it be the WVSMA's policy to support passage of legislation similar to the conference report of SB-485 with modifications to reflect the following:

(1) That in order to practice, an A.N.P. or nurse midwife must enter into and maintain a collaborative relationship with one or more licensed physicians, governed by a written collaborative agreement between them, which must include:

(a) Mutually agreed upon practice guidelines or protocols for clinical practice and communication which define the individual and shared responsibilities of the A.N.P. or nurse midwife and the physician in the delivery of health care services;

(b) Periodic and joint evaluation of services rendered; and

(c) Periodic and joint review and updating of the written practice guidelines and protocols;

(2) That while licensing of the A.N.P.s would be the responsibility of the West Virginia Board of Examiners for Registered Professional Nurses, a joint committee composed of members of that board and of the Board of Medicine must review and approve collaborative agreements and would review any allegations of misconduct on the parts of parties to such collaborative agreements.

(3) That the joint committee already referred to in (2) be responsible for developing and periodically updating a formulary of drugs which may be prescribed by those A.N.P.s and nurse midwives who have been granted prescriptive authority; and

(4) That lay midwives not be licensed.

The subcommittee believes that a consensus can be achieved among all involved parties except the lay midwives to recommend passage of legislation that incorporates these modifications of SB-485.

The Subcommittee on Rural Health, chaired by Stephen Sebert, M.D., presented the results of a recent survey of West Virginia family physicians regarding their perception of needs for physicians and allied health personnel in their communities. Comments on the advantages and disadvantages of practicing in West Virginia were also included. (The November issue of the *West Virginia Medical Journal* will feature Dr. Sebert's survey.)

In summary of the results, West Virginia family physicians feel they are able to assess the health care needs of their communities. There is a need for more physicians in all of the major specialities particularly in family practice and obstetrics. Of other health care professionals, registered nurses and licensed practical nurses are more needed. Twenty-five percent of the respondents are actively recruiting associates. Forty-eight percent have seriously considered leaving or are planning to leave West Virginia. The most commonly cited reasons for relocating are inadequate reimbursement, the state's economy, SB-576, lack of tort reforms and state government in general.

The greatest advantage to practicing in West Virginia are the people, quality of life, and home and family. The greatest disadvantages are reimbursements, state government, malpractice climate and the state's economy.

The recommendations of the Subcommittee on Reimbursement, chaired by Eugene Cordell, M.D., were incorporated in the legislative agenda under PEIA and reimbursement initiatives. The recommendations of the Subcommittee on Tort Reform, chaired by Phil Branson, M.D., also were incorporated in the tort reform provisions of the 1991 legislative agenda.

Bill Perry of the Perry & Haid Group is continuing his investigation on the funding mechanisms and operations of free clinics and rural health care centers in the state.

F. Thomas Sporck, M.D.
Chairman

Committee on Medical Education

The West Virginia State Medical Association (WVSMA) is recognized as a provider to accredit intrastate continuing medical education programs by authorization through the Accreditation Council for Continuing Medical Education (ACCME). WVSMA has maintained this role since 1972.

Two organizations have been resurveyed since the last annual report: Charleston Area Medical Center, Charleston; and VA Medical Center, Martinsburg. Both organizations were awarded four-year accreditation status. Pleasant Valley Hospital in Point Pleasant, a new organization, submitted an application and an on-site survey was conducted in September.

WVSMA currently has 20 institutions/organizations accredited for Category 1 credit of the Physician's Recognition Award of the American Medical Association:

American Heart Association WV Affiliate
Charleston, WV

Beckley Appalachian Regional Hospital
Beckley, WV

Broaddus Hospital/Myers Clinic
Philippi, WV

Charleston Area Medical Center
Charleston, WV

City Hospital
Martinsburg, WV

Fairmont General Hospital
Fairmont, WV

Jackson General Hospital
Ripley, WV

Mid-Ohio Valley CME
Parkersburg, WV

Monongahela Valley Association
of Health Centers
Fairmont, WV
(formerly Fairmont Clinic)

Raleigh County Medical Society CME Program
Beckley, WV

Reynolds Memorial Hospital
Glen Dale, WV

St. Francis Hospital
South Charleston, WV

St. Marys Hospital
Huntington, WV

United Hospital Center
Clarksburg, WV

VA Medical Center
Martinsburg, WV

Weirton Medical Center
Weirton, WV

WV Academy of Ophthalmology
Charleston, WV

The WV Academy of Otolaryngology - Head and Neck Surgery
Charleston, WV

WV Chapter, American College of Surgeons
Charleston, WV

Wheeling Area CME
Wheeling, WV

WVSMA's CME Accreditation Program was resurveyed by the ACCME on June 23, 1990. The Committee on Review and Recognition (CRR) awarded the WVSMA four-year continued accreditation. A progress report was requested and was subsequently approved. The CRR commended the committee for a job well done.

During their last meeting in January, the Committee on Medical Education approved an updated version of the Policies and Procedures and Annual Report Form, also an increase in the subcommittee from three members to five, and an accreditation certificate to be given to organizations granted continued recognition. An increase in survey fees was also approved on a sliding scale as follows (resurvey/initial survey):

(1) Specialty, other organizations, and hospitals 0-150 Beds, $100/$200;

(2) Hospitals 151-300 beds, $200/$300; and

(3) Hospitals over 300 beds, $300/$400.

The committee continues to monitor each organization in its compliance with the Essentials and Guidelines set by ACCME. The accreditation coordinator attends all site visits with the survey teams as a source of continuity and uniformity in the application of standards for institutions/organizations.

The accreditation coordinator served as a surveyor on behalf of the committee for Review and Recognition of the Accreditation Council for Continuing Medical Education (ACCME) on July 10, 1991. The resurvey took place at the Ohio State Medical Association in Columbus.

Ongoing projects for the committee include: a workshop for CME providers; annual committee meetings during the WVSMA Mid-Winter Clinical Conference; rotating CME providers who accredit WVSMA's Mid-Winter and Annual Meetings; and compiling a Policies and Procedures Manual for all committee members.

William O. McMillan Jr., M.D.
Chairman

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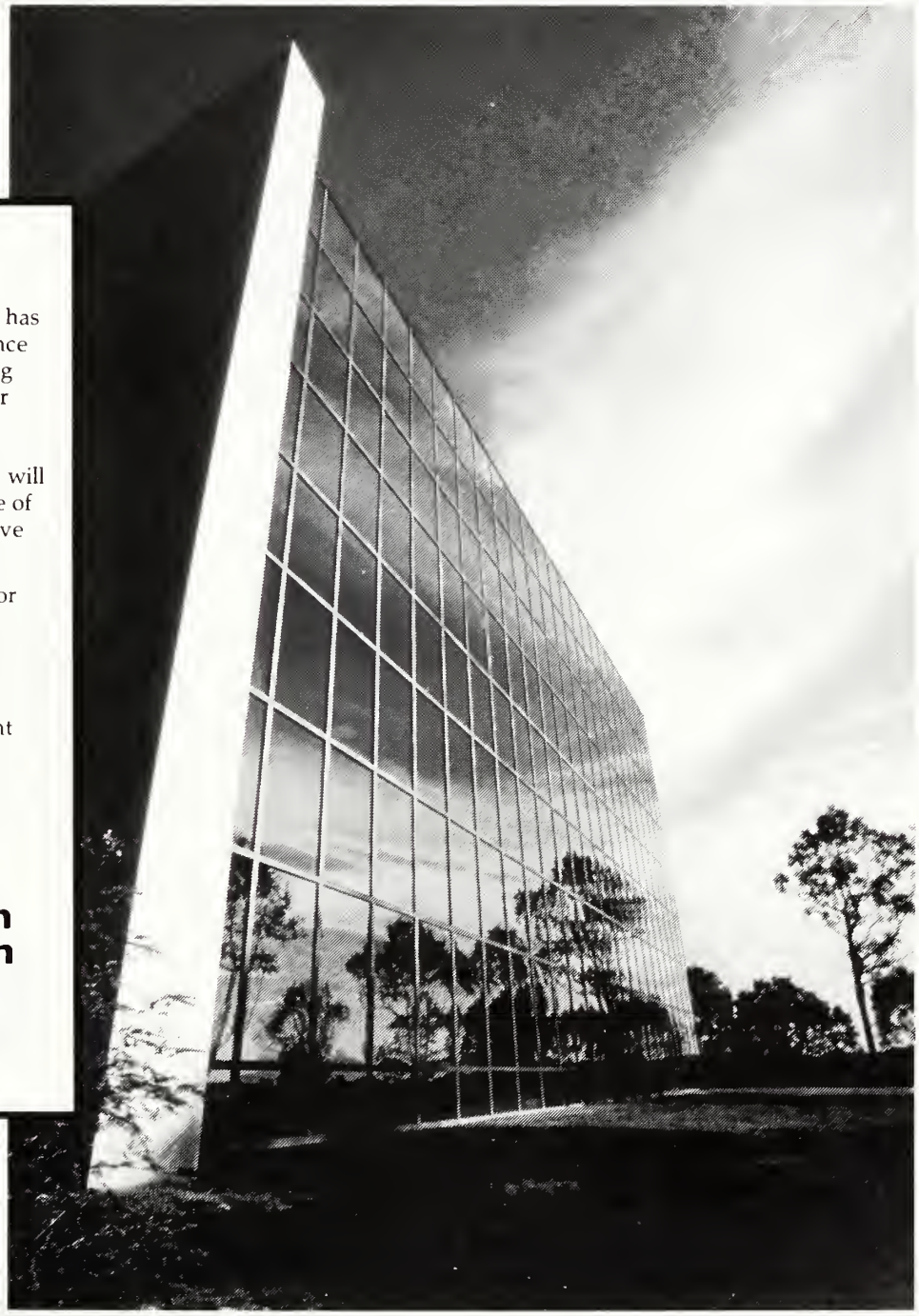

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Tourette's Syndrome and Treatment with Clomipramine Hydrochloride

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Abstract

Clomipramine hydrochloride, a tricyclic antidepressant that blocks serotonin and norepinephrine reuptake, is indicated in the treatment of Obsessive-Compulsive Disorder. It has been reported that patients with Obsessive-Compulsive Disorder and a concomitant diagnosis of Tourette's Syndrome respond well to treatment with clomipramine (1). It has also been reported that these dually-diagnosed patients, when treated with clomipramine, receive relief from the symptoms of both disorders (2).

Published reports of Tourette's patients, without a concomitant Obsessive-Compulsive Disorder, successfully responding to treatment with clomipramine are rare. To the authors' knowledge, no such report has been published since 1975. This article reports the case of a 41-year-old male Tourette's patient, without a dual diagnosis of Obsessive-Compulsive Disorder, who successfully responded to clomipramine therapy.

Introduction

Tourette's Disorder, a chronic, familial, neuropsychiatric syndrome, is characterized by facial and vocal tics, generalized jerking movements, echolalia and coprolalia. Other symptoms include obsessions, compulsions, aggressive behavior and self mutilation (3).

Tourette's Syndrome is now known to have been first reported by Itard as early as 1825. The disorder received its name from Gilles de la Tourette who, in 1885, published one of the first case reports of the syndrome. Tourette described a female patient with a systems' complex of both motor and vocal tics. The patient, the Marquise de Dampierre, had been seen by many physicians, including the famous neurologist, Charcot. Tourette's description of the disorder, which bears his name, is still applicable today (4).

The Obsessive-Compulsive Disorder is characterized by obsessions of recurrent and persistent ideas, thoughts, impulses or images; and overwhelming compulsions to repetitively perform certain acts or rituals uncontrollably (3). The obsessions or compulsions cause marked distress, are consuming, or significantly interfere with social or occupational functioning (3).

There exists an interesting correlation between Tourette's Syndrome and Obsessive-Compulsive Disorder. The reported occurrence of Tourette's Syndrome in patients with Obsessive-Compulsive Disorder is 5 percent to 7 percent. The rate of Obsessive-Compulsive Disorder in Tourette's patients is 55 percent to 74 percent (5).

In the last two decades, there has been significant study and research into the pathophysiology and etiology of Obsessive-Compulsive Disorder and Tourette's Syndrome. Unfortunately, treatment of these devastating maladies has been less than ideal.

The drug of choice in the treatment of Tourette's Disorder has been the butyrophenone, haloperidol. This neuroleptic agent blocks postsynaptic dopamine reception in the brain and has been shown to be effective in suppressing disturbing aspects of Tourette's Syndrome such as coprolalia, jerking and facial tics (6).

Despite haloperidol's proven efficacy in Tourette's Syndrome, undesirable side-effects prevent many patients from taking the drug for long periods of time. These side effects include acute dystonia, hypotension, fatigue, dyskinesia, intellectual dulling, personality changes and akathisia.

Other agents which have received significant use in the treatment of Tourette's Disorder include the noradrenergic agonist clonidine, desipramine, imipramine, and the GABAergic inhibitor clonazepam. These agents have all shown some beneficial effect in ameliorating the symptoms of Tourette's but like haloperidol, their use is limited by undesirable side effects.

Recently, the drug clomipramine has been approved for the treatment of Obsessive-Compulsive Disorder. The drug's exact mode of action is unknown, but its selective capacity to inhibit the reuptake of serotonin is presumed to influence obsessive-compulsive behavior (7).

Ratzoni and colleagues reported the case of a patient whose definite Tourette's Syndrome coexist with Obsessive-Compulsive Disorder and who responded dramatically and repeatedly, with amelioration of symptoms of both disorders, while taking clomipramine (7).

Other published reports of the use of clomipramine in the treatment of Tourette's Disorder are rare. In 1975, Yaryura-Tobias reported the use of clomipramine in the treatment of Tourette's patients who did not respond to various other treatments. He reported complete remission of symptoms in both patients while taking the drug. Symptoms returned in one patient when he was placed on a placebo and in the other when he discontinued treatment (1).

Yaryura-Tobias' report is unclear as to whether the two patients suffered from concomitant Obsessive-Compulsive Disorder with Tourette's. One patient is described as having a diagnosis of Tourette's and the second is described as having "obsessive-compulsive signs" which were ameliorated with the use of clomipramine.

Since approval by the Food and Drug Administration for the use of clomipramine (marketed under the trade name Anafranil) in the treatment of Obsessive-Compulsive Disorder, the medical community is having an opportunity to see significant benefits in the treatment of this disorder. Based upon the successful treatment of a patient with a dual diagnosis of Obsessive-Compulsive Disorder and Tourette's, a 41-year-old man who was singly diagnosed with Tourette's was placed on clomipramine. The following is a case report of this patient's treatment and response.

Case Report

The patient is a 41-year-old white male who at about age 13, began to have rather violent motor tics, including kicking and jerking. These motions were destructive in nature, i.e. doing damage to his bedroom wall by kicking, ripping curtains from windows and breaking items within the house.

Concurrently with these violent motions, the patient developed motor tics which included grimacing and jerking. Subsequently, he developed coprolalia and copropraxia.

The patient was hospitalized twice before his condition was accurately diagnosed. In the early stages, he was hospitalized for evaluation of what was felt might be rheumatic chorea. This diagnosis was not confirmed and he left the facility undiagnosed.

In 1964, at age 15, the patient became uncontrollable and was hospitalized at a psychiatric hospital. He received 21 electroshock treatments before it was determined that he suffered from Tourette's Disorder Syndrome.

The subject was discharged home on 800 mg. of chlorpromazine per day, a drug which caused him to experience orthostatic hypotension. He was placed under the care of a private psychiatrist who started treating him with trifluperazine.

With this treatment he was then able to return to high school. A drastic change was noted in his academic standing, though, because he had originally been a bright "A" student and now was a very poor "C" and "D" student, who was disruptive in class.

The patient married shortly after graduation from high school and became the father of three children. He had various trials of medication over the ensuing years, including clonidine and haloperidol.

Haloperidol seemed to work the most efficaciously and he was maintained on this drug at a dose of 5 mg. three times a day for a significant period of time. This dose was eventually increased to 5 mg. four times a day. Eventually, extrapyramidal side effects from the use of haloperidol inhibited his mobility. His cognition was also impeded.

When the dosage of haloperidol was lowered in an attempt to lessen side effects, undesirable Tourette's symptoms such as copropraxia and coprolalia were accentuated. After trial and error, the patient was maintained on 15 mg. per day of haloperidol for many years. This dosage was a compromise between the least side effects and the greatest behavior control. Unfortunately, neither goal was satisfactorily met.

As stated earlier, extrapyramidal symptoms inhibited this patient's mobility, but, to a degree, he was more content with the inability to ambulate than to have the tics prevail. The patient became a recluse, unable to go out of the house and socialize because of embarrassment to himself and his family. Outside of his family, he had no friends or social contact. This was his status at the time he was placed on clomipramine.

Initially, the patient was placed on a 50 mg., three times a day dose, and at the end of two weeks, he had the dose raised to 50 mg., four times a day. At three weeks of treatment, he was interviewed and stated that he felt as if he had emerged from a virtual "living hell" to a kind of normal lifestyle. He described himself as having been vindictive against strangers, friends and family and said that he had lied to compensate for this activity.

The patient also stated that he felt like a "zombie" on the drug haloperidol, and now these feelings had turned around so that he could try to recapture respect from his family. He now had lost almost all of his motor and vocal tics, was ambulating well, and for the first time had been able to go shopping with his wife without yelling obscenities. In addition, he had regained an interest in personal hygiene and was beginning to make friends and socialize with people.

Twelve weeks after starting the treatment, the patient continued to improve and no longer felt that he was a social misfit.

The two significant side effects he experienced were a persistently annoying dry mouth and the inability to ejaculate for the first three weeks. This second side effect had subsided by week four. It should also be noted that during the first two weeks after the start of clomipramine therapy and the cessation of haloperidol, the patient's disease became full blown. This was very distressing to him. Fortunately, by the start of week three, the syndrome was under control.

Discussion

The drug clomipramine, as described in the case report, has produced a dramatic improvement in the life of at least one Tourette's patient who did not also suffer from a concomitant Obsessive-Compulsive Disorder. This result is in keeping with the findings of Yaryura-Tobias (1) and Ratzoni and colleagues (7).

This report deals only with one patient and in order to fully access the effectiveness of clomipramine in treating Tourette's Syndrome, clinical trials utilizing many more Tourette's patients without a concomitant Obsessive-Compulsive Disorder should be undertaken.

The dosage of clomipramine used with this patient was empirical, but it would appear that in this instance, at least the 200 mg. dose is adequate, if not optimal.

It should be noted that there are side effects associated with the use of clomipramine which might make this drug unsuitable for its use in certain patients. These side effects, at least in the reported patient, are considerably less than those of haloperidol. The benefits of clomipramine therapy, initially, appear to be greater than that of haloperidol.

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Medical Grand Rounds

West Virginia University Health Sciences Center

Edited by Irma H. Ullrich, M.D., Professor of Medicine

Conquest of the Gout

Discussant:
JAMES E. BRICK, M.D.
Associate Professor of Medicine, Section of Rheumatology

Abstract

With students such as Hippocrates, Galen, Paracelsus, Sydenham, Herberden, Harvey, Cheyne, Boerhaave and Paré, the history of "The Gout" (L. gutta-drop), more than any other disorder, parallels the history of Western medicine. It also played important parts in modifying American and European culture and history. Such was the fear and honor it commanded in the last 3,000 years, that over a score of saints and holy men are credited with its cure. Long stated to be a disease of the upper class, at one time, it was considered so stylish that it was said that the only thing worse than having it was to be cured.

Early History

At a time when medicine is being increasingly criticized from all sides and asked to answer for all of mankind's foibles, the comforting constancy of "The Gout" should provide respite for all and convince even the most despondent of us that these problems, too, will pass.

Table 1
Famous People Who Suffered From Gout

Leonardo da Vinci
Alexander the Great
Francis Bacon
John Hunter
John Calvin
William Pitt (elder and younger)
Benjamin Franklin
George IV of England
Henry VIII of England
Louis XIV
Cotton Mather
Thomas Syndenham
Martin Luther

Table 2
Hippocratic Aphorisms on "The Gout"

- Eunuchs do not take the gout nor become bald
- A woman does not take the gout unless her menses be stopped
- A young man does not take the gout until he indulges in coitus
- In gouty affections, inflammation subsides within 40 days
- Swellings and pains in the joints... from gout...are relieved by a copius affusion of cold water, which reduces the swelling and removes the pain
- Gouty affections become active in spring and autumn

Gout surely is "The King of Diseases and the Disease of Kings." No other disease can claim such an illustrious group of victims (Table 1), or a pedigree of investigators and descriptors, since the dawn of reported medical history.

Much of the early history of gout parallels early Western civilization in that it centers in the Eastern Mediterranean. In the fifth century B.C., Hippocrates recognized gout as being distinct from other types of acute arthritis and tradition has it that he gave us the terms podagra ("foot seizure"), cheiragra (wrist), gonagra (knee), and omagra (shoulder-very rare). Hippocrates advocated purging and laid blame for gout upon the accumulation of evil humors, specifically phlegm, and noted that the best treatment for this disorder lay in a vigorous purging of the bowels, probably done with white hellebore, a plant related to Colchicum autumnale. Of the many aphorisms Hippocrates left us, there remain six on gout, most of which are at least partially true today (Table 2).

Other early students of gout, (many of whom themselves were afflicted) recognized other associations. A "Dissolute and Voluptuous Indulgence of Sensual Appetities" is of course among the most interesting. Thomas Sydenham (the English Hippocrates) said that

gout patients are generally, "old men or men who have so worn themselves out in youth as to have brought on a premature old age of such dissolute habits, none being more common than the premature and excessive indulgence in venery."

The relationship between venery and gout has long intrigued investigators, though there are no controlled studies to confirm or deny this association in literature. The Roman Lucian and others thought that Podagra (the foot torturess) was born of the rape of Aphrodite by Dionysus. This stern virgin was so frightful that even Jove was afraid of her. Sydenham, himself afflicted with gout, also believed that gluttony and especially reckless drinking along with physical inactivity interfered with "proper concoction" so that crude and undigested humors would finally "break out, fall upon the joints, and excite exquisite pain, heat, and acridity in the ligaments and membranes which cover the bones." To Sydenham, we are also indebted for the classic description of the acute onset of gout (Table 3); which may be the best description of any disorder.

In years past, this type of behavior and conspicuous consumption was available only to the upper echelons of society. There is little wonder, then, that the diagnosis of gout was quite stylish in Europe in the 17th and 18th centuries. In fact, we are told that Louis XIV (the Sun King) developed an acute attack of gout on November 20, 1686, approximately 48 hours after surgery on the royal anal fistula. In addition to being the first reported case of post-operative gout, which is very common, we are told that after Louie's gout attack that the gentry and aspiring gentry of France, thought it quite stylish to be afflicted by an anal fistula or the "Honor of The Gout"! Physicians of that time speak of an epidemic of these complaints in the middle and upper-middle classes, perhaps reminiscent of the Chronic Fatigue Syndrome in the 1980s.

Table 3
Sydenham's Description of "The Gout"

...towards the close of January or beginning of February...The patient goes to bed, and sleeps quietly til about two in the morning, when he is awakened by a pain, which usually seizes the great toe, but sometimes the heel, the calf of the leg, or the ankle. The pain resembles that of a dislocated bone, and is attended by a sensation as if water were poured upon the membranes of the part affected. These symptoms are immediately succeeded by a chilliness, shivering, and a slight fever...grows more violent every hour...so exquisitely painful as to not endure the weight of cloths nor the shaking of the room from a persons walking briskly therein...numerous fruitless endeavors are used to ease the pain, by continually changing the situation of the body and the part affected...

Recent Studies

In the modern era, the relationship between intemperance of food and drink with the development of gout, has been the subject of study by many modern students of the disease. The late Dr. Gerald Rodnan, remembered by Northern West Virginia physicians as an expert on scleroderma was first, foremost and most primarily a keen student of gout. In an elegant series of experiments, the results of which were published in the 1960s, Dr. Rodnan and others at the University of Pittsburgh, carefully explored the relationship between overindulgence in food and alcohol, uric acid levels, and acute attacks of gout. These studies clearly showed a relationship between alcohol intake, fasting, and gout by demonstrating that in many patients, the acute attack of gout began only after a gluttony and alcohol-induced rise in serum uric acid had begun to fall. This confirmed the previous observation by Garrod of the fall in uric acid preceding acute attacks a century before.

Though Van Leeuwenhoek had seen crystals from a tophus with his microscope in 1679, the modern history of gout is probably best said to begin with Alfred Baring Garrod's seminal monograph in 1859 on "Nature and Treatment of Gout and Rheumatic Gout." This landmark paper includes the first biochemical description of a human disease and we also see here the first disease for which medical science found the precise etiologic agent. In this publication, Garrod described his now famous "string test" in which a linen thread was dipped into the acidified serum of a patient with gout and when left to dry, evidenced crystals of uric acid (which he also demonstrated with polarized microscopy). This technique for the diagnosis of gout using synovial fluid with polarized microscopy was "rediscovered" nearly 100 years later at the University of Pennsylvania by Drs. Hollander and McCarty.

Therapy

The treatment of gout during the last 3,000 years has been almost as interesting as those that have been afflicted. Although the Greeks, utilization of white hellebore and colchicine is probably mentioned in the Ebers papyrus (1500 B.C.), popular belief has it that colchicine has only been widely used since the sixth century when it was introduced from the Province of Colchis in Asia Minor (Turkey) by the Christian Byzantine physician Alexander of Thralles. The ancients called colchicine Hermodactyl (the finger of Hermes). Colchicine was used for the treatment of gout until well into the 13th century when its use was largely discontinued because of its reputation as a poison and because the Moslems recommended it.

Despite this, purgatives of other types continued to be used for the gout well into the time of Sydenham, who condemned all purgatives for the treatment of gout based on his own personal experience, which he admitted might not be of much value since he had failed to cure himself. For centuries, colchicine, the active ingredient found in Colchicum autumnale (autumn crocus or meadow saffron) remained in the realm of folk remedies and tonics. Its use was frowned upon until its apparent rediscovery by Baron Anton Von Stoerk (physician of the Empress Maria Theresa of Austria) in 1763. It was introduced to the United States by Benjamin Franklin in 1798 as a remedy for his own gout.

In the interim between the abandonment of colchicine and its reintroduction by Von Stoerk, a number of other agents were used

to treat gout. Perhaps one of the most interesting, is the use of the extract of the chincona tree (containing, among other things, quinine) from South America. In 1638, Countess Anna of Chinchon, the wife of the viceroy of Peru was cured of a fever that had evaded treatment by court physicians by a bark extract that the Indians said came from the "fever tree." Within a year, her husband imported a boatload of this bark to Europe and established a monopoly on its sale with the Society of Jesus that was maintained for nearly 100 years. Word spread fast about this bark and Sydenham mentions its use for gout in his treatise.

In addition to being the beginning of the pharmaceutical industry, this agent was used alone and in various mixtures (probably some of which contained colchicum), for the treatment of malaria and gout throughout Europe and the colonies. The pernicious nature of the Jesuit monopoly on this bark in 1763 led Reverend Edward Stone, a member of the Royal Society, to invoke the Doctrine of Signatures (taking the treatment from the source), and to try willow bark in the belief that arthritis was related to damp, low-lying ground. He reported this substitution for chincona bark was quite efficacious for the treatment of arthritis, probably including gout and that it saved him several pounds in his practice over the use of the Jesuit's product.

The remaining history of gout and its treatment has largely involved guilding of the lily. In 1900, His injected sodium urate crystals subcutaneously, reproducing the histology characteristic of a tophus, thus in a sense confirming Koch's postulates for the gout. This work was largely ignored until the 1960s when McCarty and Hollander consistently found urate crystals in gouty effusions. In 1931, Archibald Garrod (son of the original Dr. Garrod), included gout as a metabolic disorder and coined the term "inborn error of metabolism." Since then, the enzymatic mechanisms of purine biosynthesis and defects within this pathway, such as the HGPRT deficiency that leads to Lesch-Nyhan Syndrome have been clearly described.

The foundation of effective treatment for this disorder lies upon a correct diagnosis and if there is any question about this, then synovial fluid should be obtained for crystal analysis. The diagnosis is not proven by the presence of hyperuricemia. The treatment of gout has changed little in the last 20 or 30 years. What is different though, is the approach to patients with asymptomatic hyperuricemia, which most people now agree, should not be treated in the majority of truly asymptomatic patients. An exception is the induction phase of treatment of acute leukemia where acute uric acid nephropathy may result from rapid cell death and turnover.

For the treatment of the acute attack, non-steroidal anti-inflammatory drugs, chiefly by tradition indomethacin, has largely supplanted colchicine. There is still a role for colchicine in special situations. These include questionable diagnoses and intraveneous colchicine for patients unable to take non-steroidals, such as in the postoperative period. Prophylaxis for acute attacks is still treated by many physicians with daily small doses of colchicine or a non-steroidal anti-inflammatory drug.

For patients with recurrent acute attacks and hyperuricemia, a uric acid lowering drug such as allopurinol or probenecid should be used. The frequency of acute attacks warranting institution of anti-hyperuricemic therapy is a decision that must be arrived at based on the patient's and doctor's preferences. These drugs are not used for the treatment of acute attacks, and in fact may prolong them or precipitate them. Corticosteroids or ACTH, have also been used in some patients for treatment of acute attacks. These may be of most value in patients unable to take colchicine or non-steroidal anti-inflammatory drugs or in patients unresponsive to those measures.

In conclusion, the best advice on gout, and probably most all of life comes from Ben Franklin, a victim and scholar:

> Be temperate in wine, in eating, girls and sloth:
> Or The Gout will seize you and plague you both.

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Manuscript Information

Manuscripts to be presented for publication in the *West Virginia Medical Journal* should be prepared in accordance with "Uniform Requirements for Manuscripts Submitted to Biomedical Journals" (1) (International Committee of Medical Journal Editors).

The *West Virginia Medical Journal* will not consider for publication a paper or work that already has been reported in a published paper, or is described in a paper submitted or accepted for publication elsewhere.

Manuscripts, accompanied by one copy, should be typewritten, double-spaced, on one side only of white bond paper (8½ by 11 in.), with margins of at least one inch.

Use double spacing throughout, including (in the following order) title page, abstract, text, acknowledgements, references, tables, and legends for illustrations. Begin each of the following sections on separate pages: title page, abstract, text, acknowledgements, references, individual tables, and legends for illustrations. Number pages consecutively, beginning with the title page. Type the page number in the upper right-hand corner of each page.

Articles contained on computer diskettes are acceptable and encouraged. Please contact the *Journal* in advance to determine the format type to be used. The conventional manuscript as described above must accompany the diskette.

All persons designated as authors should qualify for authorship. Each author should have participated sufficiently in the work to take public responsibility for the concept.

The second page should carry an abstract of no more than 150 words summarizing the manuscript.

Where reference is made to generically-designated drugs, the first such reference must be followed by parentheses containing the most commonly known trade-name drug of that designation. In addition, a listing of all generic drugs mentioned in the article, with their trade-name equivalents, should appear at the end of the article.

Tables (tabular listings) and figures (photos, drawings and charts) should be numbered and the point of reference in the text indicated in parentheses, i.e., (Table 1), (Figure 1).

Photos must be good-quality unmounted glossy prints usually 5 by 7 in. but no larger than 8 by 10 in. Black and white photos are preferred. Color photos will be printed in black and white. Cost of printing photos in excess of four will be billed to the author.

Each photo (figure) should have a label pasted on its back indicating the name, its number and an indication of its "top." A separate legend should be provided for each photo. Do not write on the back of photos, or scratch or mar them using paper clips. Do not mount them on cardboard. Drawings and charts should be done in solid black on pure white.

Number references consecutively in the order in which they are first mentioned in the text. Identify references in text, tables, and legends by arabic numerals (in parentheses).

No more than 25 references will be published free of charge to the author.

Use the style of references seen in this *Journal*, which is based on the formats used by the U. S. National Library of Medicine in *Index Medicus*. The titles of journals should be abbreviated according to the style used in *Index Medicus*. Consult "List of the Journals Indexed," printed annually in the January issue of *Index Medicus*.

All scientific material appearing in the *Journal* is reviewed by the Publication Committee. Manuscripts should be mailed to The Editor, West Virginia Medical Journal, Box 4106, Charleston, WV 25364.

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From 1980 through 1986 Phil served as the Director of Medicare Claims for Blue Cross and Blue Shield of Kansas City, Missouri, where he was responsible for receipt and processing of Medicare Part B claims, the establishment of reasonable charge levels, and utilization review controls.

Phil has also authored two Medicare texts: *The Doctor's Guide to Medicare,* and *Medicare in the 90's, a Medicare Workbook.* In addition, Phil serves as a columnist for *The Health Niche Advisor.*

SEMINAR REGISTRATION INFORMATION

Date/Time: December 5, 1991 8:30 am—3:30 pm
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Cancellations: Deadline December 2, 1991

To register by phone or for more information Call Simpson & Osborne at (304) 343-0168.

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President's Page

Constantino G. Amor M.D.

Politics and the Extra Effort

Two extraordinary events in 1992 will produce a dramatic change in the political environment in West Virginia -- impacting on the practice of medicine in the state. 1992 will bring the gubernatorial election with reapportionment/ redistricting of congressional and state legislative districts and a final report embodying legislative initiatives from the Health Care Planning Commission.

The questions are -- will we be prepared and how will we respond?

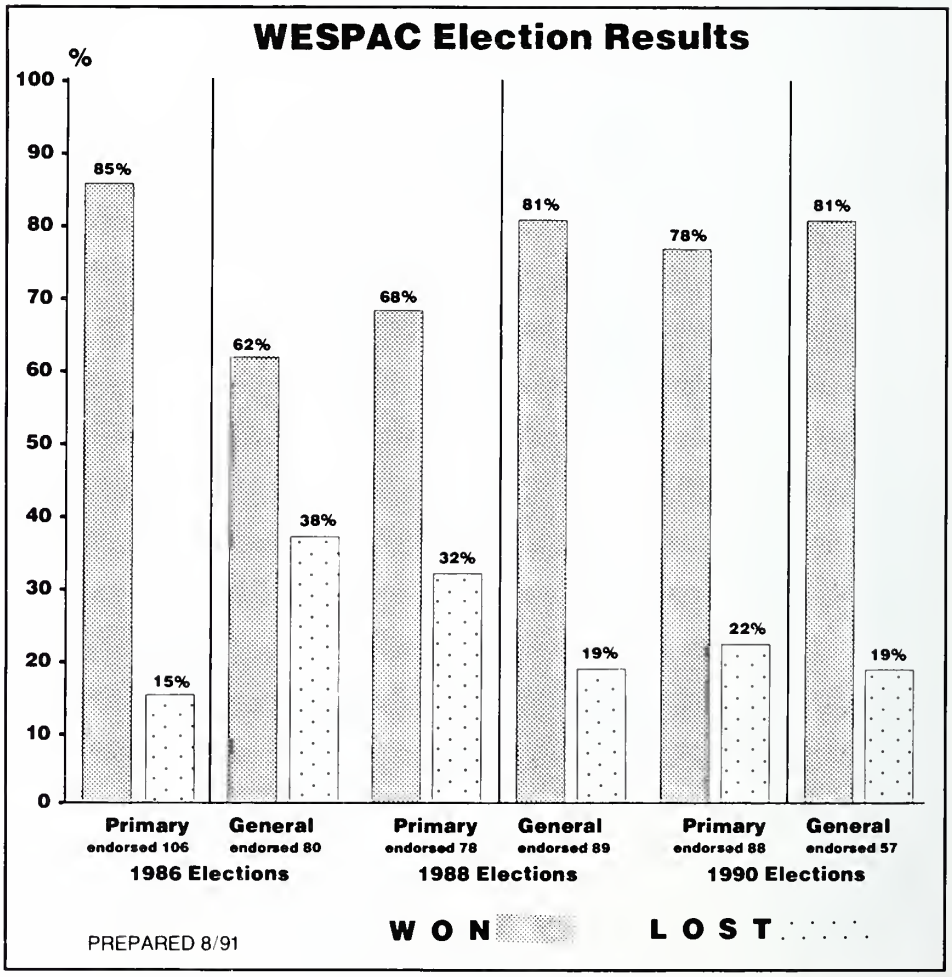
West Virginians will either re-elect Gaston Caperton or put a new governor in office. In either case, groundwork has been done on who those candidates will be. Almost daily, the newspapers provide an account of political maneuvering or spotlight a particular gubernatorial hopeful, or yet undeclared candidate.

Every 10 years, as mandated by the U.S. Constitution, a count is made of the number of people living in the United States. Once these figures have been tabulated and analyzed, the 50 states learn how many representatives they are entitled to receive. This process is called reapportionment. After this is done, each state redraws its legislative and congressional districts -- a procedure which is called redistricting.

According to the 1990 census figures, 21 states will be affected. Eight states will gain seats and 13 will lose. Most of the shift, as was expected, comes from northern and midwestern states losing seats to southern and western states. West Virginia will lose a congressional seat because our population shift resulted in a direct drop of over 8.5 percent. In 1980, our population was over 1.9 million, but the 1990 census revealed that there are now only 1.7 million people living in the state.

Drafts of various scenarios of redrawing our congressional districts from four to three are being floated about and the lines may be decided in the current Special Legislative Session At this conjecture, it looks as if two of our congressmen may be vying for one seat. There may also be newcomers in the races for congressional seats once the lines are drawn.

A proposal to reapportion the current 40 House of Delegates multimember districts into 100 single member districts, and some repositioning of the senatorial districts, has drawn both criticism and support. No doubt, political considerations will influence any



plan considered of which the majority party will control this process. Do not be surprised, however, if the courts ultimately draw the district lines.

Depending on how the district lines are drawn, the politically ambitious may aspire to a congressional seat. This could result in some open seats in the state Legislature and a change in leadership after the election. Further, if the change from a multimember district in the House to single member districts evolve, there will be some upsets with incumbents and openings for newcomers. This scenario presents the medical community with more opportunity for participation in the political process. In summation, there will be some changes made in the Legislature and in our representation in Congress.

The Health Care Planning Commission, established as a result of action taken in the 1991 regular legislative session, has been meeting over the summer months taking testimony and gathering information on health care issues and initiatives. The commission is now in the stage of conducting public hearings around the state in preparation for a report which will be submitted by November. However, the final report and any proposed legislation would not be submitted to the Legislature until January 1993. It is important to note that these recommendations for legislative change will come after the 1992 elections.

WVSMA is in the preparatory stage of compiling information and developing positions for the *1992 White Paper*. Segments of the *White Paper* will highlight the legislative initiatives sought and our position on various controversial issues, in particular a single-payor, universal health care system. This prototype of a Canadian health care system is being considered by the Health Care Planning Commission as a solution to health care access and the cost of insurance problems in West Virginia.

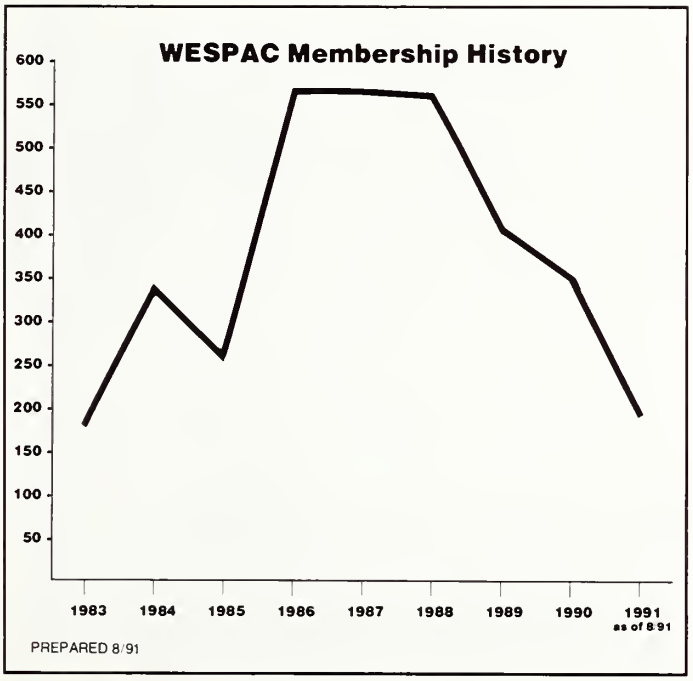
The uncertainty of the election and of the final recommendations of the Health Care Planning Commission, present an opportunity for the medical community to be a major player in the outcome. How well we organize and proceed to affect change in the 1992 elections depends on the strategies employed and the cooperation received. One of the most effective tactics is the WVSMA key contact system, whereby physicians and auxilians have an established relationship with a specific state legislator, U.S. representative or senator on issues of great importance to medicine. Key contacts are our grass roots system, and the WVSMA Auxiliary has designed a nationally recognized key contact training program that is available for your county society just by calling the WVSMA office.

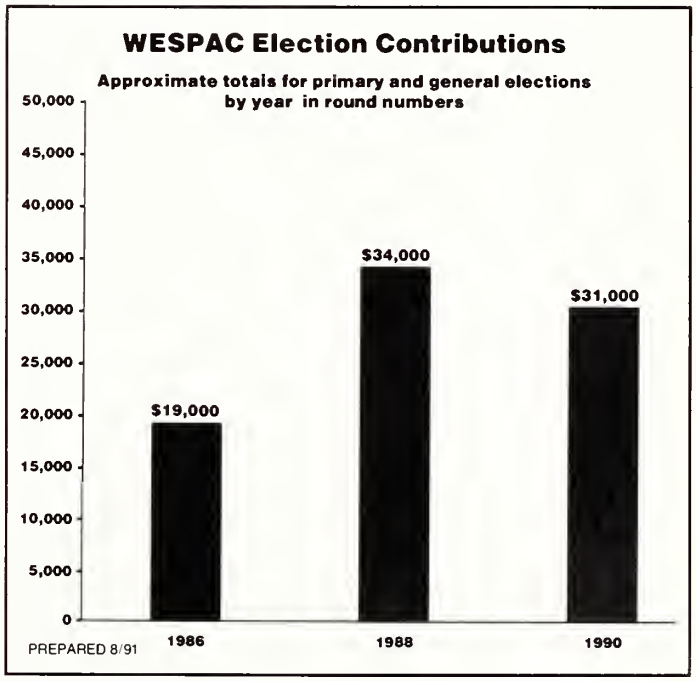
The WVSMA Auxiliary also plans to proceed this year with two political programs in which each county medical society can become involved -- a voter registration drive and a candidate forum. To make these programs a success, it is vital to contact your local auxiliary and express your interest and cooperation.

Other political actions that members could pursue include working on behalf of a candidate or political party, encouraging others in the medical community to get involved, communicating your views to legislators, and providing financial support to a candidate's campaign or to WESPAC/AMPAC.

In response to the latter, it is essential that we empower our political action committee, WESPAC/AMPAC, with our money and our participation. WESPAC/AMPAC will need to influence the process, thus, the outcome of the 1992 elections.

In state legislative races, WESPAC decides where support is appropriate, which candidates are worthy of consideration and also advises AMPAC on congressional seat races. Those decisions are made from a





number of criteria including WESPAC's Candidate Selection Committee, comprised of representatives from county medical societies. WESPAC does not endorse gubernatorial candidates, but encourages physicians and their families to be involved in the campaigns. Likewise, AMPAC does not endorse presidential candidates, but encourages bipartisan participation from the medical community.

In 1990, 81 percent of the 57 candidates endorsed by WESPAC in the general election were elected. Of those endorsements, 19 percent lost, which indicates WESPAC is fairing better in their endorsements over the 1986 General Election, in which 38 percent of the endorsements lost. Generally, a larger number of endorsements are lost in the primary elections. (See **Table 1** on WESPAC Election Results.)

There is no other group in all of organized medicine that is more democratic and more responsive to the political needs of the local medical community than WESPAC/AMPAC. Yet, the number of WVSMA members electing to join WESPAC has yet to reach 50 percent. WESPAC membership has fallen dramatically since the 1986-88 period when the liability-malpractice insurance availability and affordability crisis hit physicians. As you can see from **Table 2** which depicts WESPAC membership history from 1983 to August 1991, membership peaked with 559 members in 1988. Currently, WESPAC membership is 245.

WESPAC competes with over 200 political action committees registered with the secretary of state's office. Some of the more notable ones to compare with are the WV Trial Lawyers and the WV Education Association (WVEA). For example in the 1988 elections, trial lawyers contributed over $65,000 to candidates, and the WVEA gave some $82,000, in comparison to WESPAC's contributions of around $35,000. In the 1990 elections, trial lawyers' contributions were down to about $50,000 whereas, the WVEA gave close to $102,000 to candidates and WESPAC contributed $31,000. These actions have made a difference in the makeup of the Legislature because there are now many more teachers than lawyers serving in the House and Senate. WESPAC's election contributions for 1986, 1988 and 1990 are presented in **Table 3.**

We have an opportunity to create an impact in the political arena which has never been greater than it will be in the 1992 elections. Our success will depend on physicians and their spouses and the entire medical community establishing a strong political force.

I strongly encourage all WVSMA members and their families to enter the political action arena, for if you do not, Congress and the West Virginia Legislature will determine how you practice medicine.

—Constantino Y. Amores, M.D.

Annual membership in WESPAC/AMPAC is $50 for Regular membership, $100 for a Sustainer and over $100 for Extra Miler memberships. Membership dues are shared with AMPAC. At the $50 level, AMPAC receives $20, and at the $100 and over level, AMPAC receives $50. AMPAC contributes to federal candidates and files reports with the Federal Election Commission. WESPAC contributes to state candidates and files reports with the secretary of state's office.

Special Correspondence

A Letter to WVSMA Members

I would first like to thank the membership for electing me as your vice president during the past year. I accepted this charge with willingness and the expectation that I would proceed to serve you through the successive offices.

However, last year my practice lost a physician, leaving only two of us to serve our community. Without a three-doctor office, I could not be effective in providing adequate care for our community and serving as president of the WVSMA. Therefore, I asked the Nominating Committee not to nominate me for president-elect.

I deeply appreciate the confidence, encouragement and support given by many physicians and the WVSMA staff during my year as vice president, and for their understanding of my medical practice situation and my decision not to proceed to president-elect. I also thank my partner, James E. Bland, M.D., and my office staff for their support through the last year.

I will continue to serve West Virginia and the medical profession in other ways. I will still be involved at national, state and local levels of organized medicine. I will still be a delegate to the AMA for my specialty.

Thank you for giving me the opportunity to serve.

James L. Bryant, M.D., F.A.C.S.

Jack Leckie, R.I.P.

How can anyone ever think of Jack Leckie without a smile making its appearance? Usually it's a grin at some happy rememberance -- a man who told outrageous stories -- punch lines with himself as the gulled victim.

He would hurt no one by word or act. A sensitive man, tuned in to the tenderest feelings of others. How can one not miss a man such as this? How can the human race afford not to miss such men? Can we afford to miss goodness in this world?

Jack Leckie died September 7, 1991. He was 74 years of age.

Born in Toler, Ky., the youngest of 12 children, Dr. Leckie attended public schools in Huntington where his family moved when he was 10 days old. He received an undergraduate degree in chemistry from Marshall University in 1938, and was awarded his M.D. degree in 1950 from the George Washington University School of Medicine in Washington, D.C. After interning at the U.S. Marinel Hospital in New Orleans, Dr. Leckie began family practice in Huntington in 1951.

Dr. Jack Leckie

During World War II, Dr. Leckie served as a commissioned line officer with the U.S. Navy Amphibious Force in the European Theatre and with the Navy's Bureau of Ships. He assisted in plans for post war atomic tests at the Bikini Atol in the Pacific.

It was 16 years ago that he served as our president. The interim AMA meeting that year was held in Hawaii -- a place God designed for such as Jack. He shone there as a leader, as a humorist and as a man of compassion.

Following his presidency, he remained active in WVSMA affairs as alternate and then delegate to the AMA House of Delegates. He also served as chairman of the Insurance Committee, a post in which he served faithfully and well for many years and, one in which he was held in great respect by representatives of the insurance industry.

Dr. Harry Weeks, in his letter below, speaks of his personal sadness at Jack's passing. There were few closer than these two during Jack's years of service to the association. Of course there is sadness.

Of course there is gratitude, too, for the opportunity to have known such a man. And there are the memories -- the happy ones ending with a smile.

Members of the Publication Committee join with members of the administrative staff of the WVSMA, doctors throughout the state and, indeed, doctors throughout the AMA, in expressing our condolences to Jack's wife, Barbara, and son, Steve, at so grievous a loss. We have all lost a friend.

— SDW

Our Readers Speak

Dr. Leckie's Death A Tragic Loss

Jack Leckie was laid to rest September 7, 1991. He was my friend. Nothing else needs to be said. But Jack made me laugh -- at the world around us and at myself -- a gift of enormous value. Jack knew secrets of life and living that many in the medical profession will never know. He was a good doctor.

I worked with Jack in the WVSMA and AMA. He and I shared a notion that young physicians should be in decision-making roles whenever possible, simply, because they have to live with their decisions longer.

At the AMA level, we both realized that it ran like the U.S. Congress and we worked hard to make contacts to keep West Virginia effective. Virtually all of the recent AMA presidents, and a majority of the current trustees, relied on Jack to help them get elected. We concentrated on picking the "right" man for key positions.

Jack worked selflessly for the profession he loved. He also had the ability to call things as they really were -- something sadly missing in organized medicine.

Jack is dead. I have lost a friend. I am sad. Very sad.

Harry Weeks, M.D.
Wheeling

Mid-Winter Physician Session to Discuss RBRVS

The concurrent sessions for physicians and the public at this year's WVSMA Mid-Winter Clinical Conference, January 24-26 at the Radisson Hotel in Huntington, will highlight the topics of RBRVS and medical ethics.

Scheduled speakers for the Physician Session, "The Realities of the RBRVS," are Marc J. Segal, Ph.D., director of the AMA's Department of Health Care Financing and Organization; and Chester Stroyny, regional administrator for Region V of the Health Care Financing Administration. Dr. Segal's presentation is entitled "Medicare Physician Payment 'Reform': Current Status," and Mr. Stroyny will speak on "Implementation of Physician Payment Reform." Biographical information on these two speakers begins below and the panelists for the Public Session on "Medical Ethics: Who Lives, Who Dies, Who Decides," will be featured in an upcoming issue of the *Journal*.

A registration form for the Mid-Winter Clinical Conference will be printed in next month's *Journal*. For more information, contact Nancie Divvens at 925-0342.

Dr. Segal

Mr. Stroyny

Panelists Highlighted

Dr. Segal received his bachelor's degree in political science from the University of Rochester in 1979 and joined the Department of Political Science at the Massachusetts Institute of Technology as a research assistant. In addition to his research duties at MIT, Dr. Segal worked as a consultant during 1981 for the National Academy of Sciences in Washington, D.C., on the study of community integration of health services.

In 1983, Dr. Segal relocated to Chicago to accept a position as senior health policy analyst for the AMA's Department of Health Care Resources. Two years later, he was promoted to his current post as director of the AMA's Department of Health Care Financing and Organization. In this role, he develops policy analysis on physician payment, long-term care, managed care and related issues, and acts as the principal AMA staff liaison with the Harvard University resource-based relative value scale (RBRVS) study.

Dr. Segal has written several articles for legal and medical journals and has made numerous appearances on television and at conferences to discuss the RBRVS issue. He is a member of the American Association of Medical Society Executives, the American Political Science Association and the American Public Health Association.

Mr. Stroyny was appointed the regional administrator for Region V of the Health Care Financing Administration in January 1988, and he is responsible for directing Medicare and Medicaid programs in Illinois, Indiana, Ohio, Minnesota, Michigan and Wisconsin. Prior to accepting this position, Mr. Stroyny was associate regional administrator for HCFA's Division of Health Standards and Quality, where he worked to assure quality health care services were provided for Medicare and Medicaid beneficiaries.

Mr. Stroyny was selected for participation in the President's Executive Exchange Program in 1978 and spent a year with General Motors as a corporate staff member in the health care section of the Employee Benefits Department. At GM, he worked primarily on health care cost containment initiatives and assisted in the company's triennial contract negotiation with the UAW.

A 1986 graduate of the DHHS Senior Executive Service Candidate Development Program, Mr. Stroyny has had executive assignments in HCFA headquarters in Baltimore, as well as participated in the LEGIS program. In his LEGIS assignment, he served six months in Washington, D.C., as special assistant to Congressman John E. Porter on legislative matters relating to the Labor, Health and Human Services and Education Appropriations Subcommittee.

Medicare Manager Speaking on RBRVS at Society Meetings

Deanna Myers, district Medicare manager for Nationwide Insurance, has begun personally speaking at component society meetings to help inform WVSMA members about topics pertaining to physician payment reform such as the RBRVS (Resource-Based Relative Value Scale), the MVPS (Medicare Volume Performance Standard), limiting charges, GPCI (Geographic Practice Cost Studies), and coding.

Nancie Divvens, WVSMA executive assistant, is assisting Deanna with these presentations which will be given until the end of 1992.

If you would like to have Deanna speak to your component society, please contact Nancie Divvens at 925-0342 and provide her with at least three tentative dates to enable scheduling flexibility.

AMA Media Tour

WVSMA President Dr. Constantino Amores gestures as he and AMA representatives Dr. John Seward (second from left) and Mark Stuart (fourth from left), and WVSMA Associate Executive Director Thom Stevens explain to Dan Page, editor of *The State Journal*, how the proposed Medicare physician payment schedule will affect patients. Dr. Seward and Mr. Stuart were recently in Charleston to meet with the *Charleston Gazette, Charleston Daily Mail* and *The State Journal* as part of their 20-city media tour to talk about the implications of the HCFA's turnabout in implementing the RBRVS.

Annual Conference for Special Children Scheduled at Canaan

"The Second Annual Surgeon General's Follow-up Conference for Children with Special Needs — West Virginia's Response," will be held November 15-16 at Canaan Valley State Park.

This two-day conference is a collaborative effort of the W.G. Klingberg Center for Child Development at the WVU School of Medicine; Handicapped Children's Services; and the U.S. Office of Maternal and Child Health. It is intended for parents, pediatricians, family practitioners, nurses, social workers, educators, early intervention specialists, therapists, legislators and child care providers.

The WVU Office of CME certifies that this seminar meets criteria for 9 credit hours in Category I of the AMA's Physician's Recognition Award. The meeting has also been approved for .9 continuing education units. Application has been made for social work contact hours.

For more details, call the Office of CME at 293-3937 or Carrie Westbrook at the W. G. Klingberg Center for Child Development at 293-7331.

Agreement Establishing USMLE Signed

James R. Winn, M.D., executive vice president of the Federation of State Medical Boards (FSMB), and Robert L. Volle, Ph.D., president of the National Board of Medical Examiners (NBME), signed an agreement which created the United States Medical Licensing Examination (USMLE). The contract signing took place during a meeting of representatives of the two organizations in Washington, D.C.

The USMLE replaces the two currently existing examination sequences used in the medical licensing process: the Federation Licensing Examination (FLEX) and the certifying examinations of the NBME. USMLE provides a common evaluation system against which to measure applicants for medical licensure. USMLE is a progressive, three-step examination. All three steps must be completed to provide adequate assessment for initial medical licensure.

Phase-in USMLE begins in 1992 with the first administration of the USMLE Step 1 in June. Full implementation of the USMLE Steps 1 through 3 and phase-out of the FLEX Components 1 and 2 and NBME Parts I, II and III will be completed by 1995.

For further information, contact the USMLE secretariat in Philadelphia at (215) 590-9600.

Board Reminds Physicians of Dispensing Rules

It has come to the attention of the Board of Medicine that some physicians in the state may not be aware if a physician administers controlled substances to a patient in his or her office, that physician must be registered with the board as a dispensing physician.

The Board of Medicine rules for dispensing of legend drugs by physicians and podiatrists are contained in the white booklet mailed to all physicians who renewed their licenses in 1991. The definition of "dispense" in the rules includes administering drugs. The full rules begin at page 149 of the booklet, "*West Virginia Board of Medicine Medical Practice Act and Legislative Rules 1991.*"

New Faculty Join Health Sciences

Dickman

Nease

Mears

Rosencrance

The Charleston Division of the WVU Health Sciences Center has recently added 10 new physicians to their faculty.

New assistant professors at the Health Sciences Center include Drs. James Mears and Daniel J. Dickman in the Department of Family Medicine; and Drs. E. Reed Heywood and Tamer Yalcinkaya in the Department of Obstetrics and Gynecology.

Appointed clinical assistant professors in the Department of Internal Medicine are Drs. Sarah Nease, J. Gregory Rosencrance and Mark Newbrough. In addition, Dr. Thomas VonDohlen has joined the department as an associate professor.

In other appointments, Dr. Ali AbuRahma has been named professor and chief of vascular surgery in the Department of Surgery; and Dr. Richard Umstott has been named an instructor in the Department of Surgery.

Impairment Rating Topic of Workshop

The Institute of Occupational Health and Safety and the WVU School of Medicine are sponsoring a workshop entitled "Impairment Rating in Workers' Compensation" on Saturday, October 26 at the WVU Health Sciences Center Auditorium in Charleston.

This seminar will feature speakers from the medical and legal professions discussing the issues surrounding impairment rating. CME credits will be offered.

For more details, contact Carolyn Bolyard at 293-3693.

Seminar Highlights Laser Surgery

Advances in the use of laser surgery for a broad range of procedures, including coronary angioplasty, laparoscopy in general surgery, and tonsillectomies, will be reviewed by specialists during "Laser Surgery Seminar VIII" scheduled for Saturday, November 16 at the Charleston Marriott.

Co-sponsored by the Eye and Ear Clinic of Charleston, Inc.; the Department of Surgery of the WVU Health Sciences Center, Charleston Division; and the Charleston Area Medical Center, this seminar is designed to update physicians, nurses, nurse anesthetists and other health care professionals on current successful laser procedures. Topics include lasers for radical neck dissection, gastroenterology, adjunctive ovarian surgery, diabetic retinopathy, anesthesia in laser surgery, features of the SLT laser, and the nursing role in laser surgery. Speakers include faculty from Johns Hopkins medical institutions, the University of Cincinnati Medical Center, Pittsburgh Laser Center, University of Kentucky, WVU Health Sciences Center and the Eye and Ear Clinic of Charleston, Inc.

Contact Mary Jane Willis, PA, program coordinator, at 353-0227 or toll-free in West Virginia at 1-800-642-3049, for more information.

WVSMA Surgery Section Holds Annual Meeting

Dr. Victor Fazio, chairman of the department of colorectal surgery at the Cleveland Clinic Foundation, was the featured speaker at this year's annual breakfast meeting of the WVSMA Surgery Section on Friday, August 16 at The Greenbrier.

Dr. Fazio, who was also a panelist at the WVSMA's Annual Meeting, spoke on the subject of "Inflammatory Bowel Disease."

In other business, the WVSMA Surgery Section voted to have a trauma-related topic for their 1992 program. The members present also stated that they want to emphasize their annual meeting is open to all interested WVSMA members, not just surgeons.

CNA Offers New HIV Insurance for Professionals

The CNA Insurance Companies plan to introduce early next year a special extra expense coverage for health care professionals who subsequently test HIV positive. This new coverage will become part of the basic professional liability coverage.

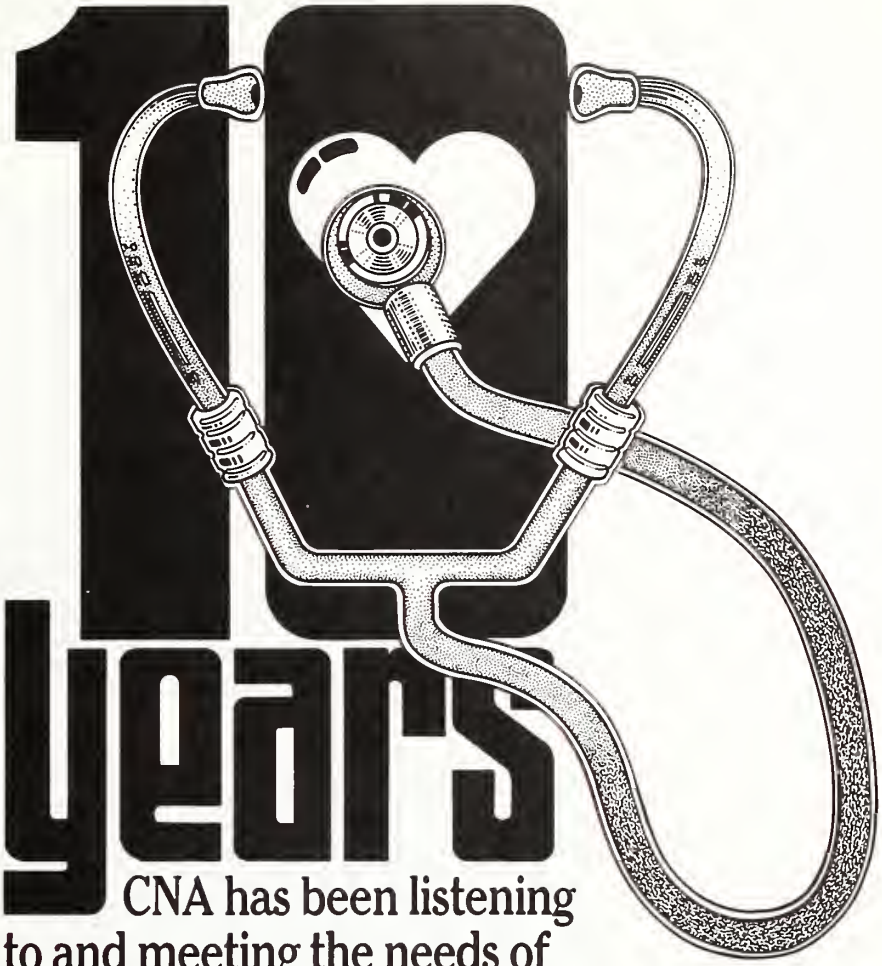
CNA provides professional liability insurance to more than 600,000 physicians, surgeons, dentists and nurses who will be covered under this program.

"This coverage will enable health professionals to realize a measure of financial security while dealing with the issues associated with the exposure to the AIDS epidemic," said Jon Carothers, vice president of CNA's professional liability division. "It is coverage we developed in recognition of the financial and professional challenges facing health care providers who risk exposure to this disease and who may transmit it to others."

The coverage, which will become part of the medical and dental policies underwritten by CNA, provides a lump sum or monthly "extra expense" payment when the insured presents proof of claim. It is offered on a "claim reported" form, so the policy that is in effect at the time the professional tests positive for HIV covers the claim. This is another step that CNA has taken to work with health care professionals to assist them in controlling loss, Carothers said, emphasizing that in order to qualify for coverage they will be required to follow all the professional standards for infection control.

Practicing physicians, surgeons and dentists will be eligible for benefit payments of $150,000. Nurses insured through CNA's Nurses Program will be eligible for payments of $25,000.

Carothers said that the extra expense coverage is subject to state insurance department approval and that CNA's goal is to offer this coverage by January 1.



CNA has been listening to and meeting the needs of WVSMA physicians for 10 years.

For 10 years, we've been working closely with the West Virginia State Medical Association and listening to the needs of physicians.

What we've learned from you has helped us to understand the special risks individual physicians face and to develop a professional liability program that's tailored to meet your exact needs.

The WVSMA/CNA Physicians Protection Program includes comprehensive professional liability coverage, local West Virginia claim service and loss control programs that meet the needs of WVSMA physicians.

Should a claim occur, we have the expertise to defend you vigorously or resolve the claim fairly and promptly. However, you can be sure no claim will ever be settled without your consent.

Listening to your needs and responding to them is just one of the many reasons the WVSMA has endorsed the WVSMA/CNA program for so long.

For more information, contact:

McDonough Caperton
Insurance Group
One Hillcrest Dr. East
P.O. Box 1551
Charleston, WV 25326-1551
(304) 346-0611

WVSMA
P.O. Box 4106
Charleston, WV 25304
(304) 925-0342

The WVSMA/CNA Physicians Protection Program is underwritten by Continental Casualty Company, one of the CNA Insurance Companies/CNA Plaza/Chicago, IL 60685.

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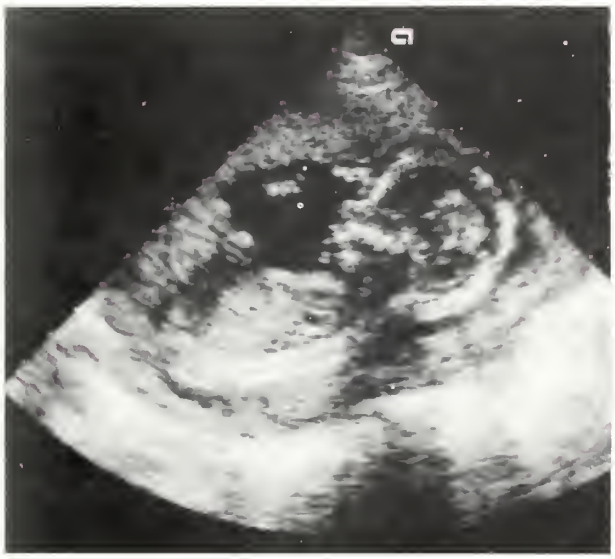
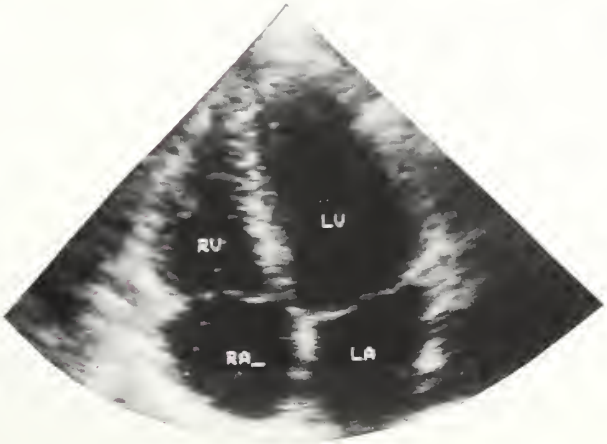




Ophthalmology
Breast
Thyroid
Encephalography
Carotid Artery
Peripheral Vascular
Echocardiography
Abdominal
Obstetrical

Continuing Education

Listed on this page are some of the upcoming continuing education programs which will be held throughout the state.

The programs this month were compiled by the following individuals: Robin Rector, coordinator of CME for Charleston Area Medical Center; Cynthia Kemp, WVU conference planner; David Bailey, MU director of CME; Marie Chute, secretary of the Ohio Valley Medical Center CME Department; and Thelma Wilson, education coordinator of the Raleigh County Medical Society.

These programs are tentative and subject to change. Further details about these CME activities may be obtained by calling Rector at 348-9580; Kemp at 293-3937; Bailey at 696-7018; Chute at 234-8310; and Wilson at 255-6341. Other national and state meetings are listed in the Medical Meetings Section of the *Journal*.

This schedule is presented as a convenience for physicians. If you would like to have the continuing education programs offered by your institution or association published in the *Journal*, please contact Nancy Hill, managing editor, at 925-0342.

CAMC/WVU Health Sciences Center - Charleston

Oct. 18 - "Anxiety Disorders," Room 2000, WVU Health Sciences Center, 12:30 a.m. - 4:30 p.m.

Oct. 19 - "Planning a Research Project," Room 2000 AB, WVU Health Sciences Center, 8:30 a.m. - 12:30 p.m.

Oct. 28 - "Evaluation and Treatment of Failure to Thrive," (Teleconference), Room 2014AB, WVU Health Sciences Center, 12:30 p.m. - 1:30 p.m.

Oct. 30 - "Determining the Patient's Capacity to Decide," WVU Health Sciences Center Auditorium, 8 a.m. - 3 p.m.

WVU Health Sciences Center - Morgantown

Oct. 25-26 - "Pediatric Oktoberfest"

Nov. 1-2 - "Internal Medicine Update 1991"

MU School of Medicine - Huntington

Nov. 8-10 - "5th Annual Family Practice Weekend and Sports Medicine Conference," sponsored by Family Medicine Foundation of West Virginia, the MU Department of Family Medicine and Community Health, the MU Division of Sports Medicine, and Scott Orthopedic Center, Inc., Radisson Hotel

Ohio Valley Medical Center - Wheeling

Oct. 23 - "Cephalosporin Update 1991," V. Chokkavelu, M.D., FACP, academic staff member, OVMC, 8 a.m.

Oct. 30 - "Pulmonary Embolism," Brian W. Carlin, M.D., director of Pulmonary Rehabilitation, Allegheny General Hospital, 8 a.m.

Raleigh County Medical Society-Beckley

Oct. 24 - "Use and Abuse of Antimicrobial Agents," Michael Seber, M.D., Black Knight Country Club, 6:30 p.m.

Oct. 26 - "A Look at Cancer Today," Scott Jones, M.D., Stephen Edge, M.D., Peyton Taylor, M.D., VA Medical Center Auditorium, 9:15 a.m.

Oct. 30 - "Endometriosis," Roger Toffel, M.D., Black Knight Country Club, 6:30 p.m.

Outreach Programs

Key to Sponsors

★ WVU Health Sciences Center, Morgantown

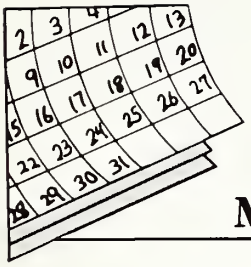
☐ CAMC/WVU Health Sciences Center-Charleston

(Check locally for more details)

Logan ☐ Logan General Hospital, October 18, 11:30 a.m., "Breast Cancer," Steven Jubelirer, M.D.

Man ☐ Man Appalachian Regional Hospital, October 22, 7 p.m., "Pediatric Surgical Problems," Eduardo Suson, M.D.

Spencer ☐ Roane General Hospital, October 22, 12:30 p.m., "Traumatic Brain Injury," Evalyn Bishop, Ph.D.



Medical Meetings

October

20-25—American College of Surgeons, Chicago.

24-26—American Academy of Clinical Psychiatrists, New Orleans.

26-30—American Society of Anesthesiologists, San Francisco.

27-31—American Academy of Physical Medicine and Rehabilitation/American Congress of Rehabilitation Medicine, Washington, D.C.

28-31—Intrastate Postgraduate Medical Association, New Orleans.

30-Nov. 3—Cosmetic Dermatologic Surgery Seminar/6th Annual Dialogues in Cosmetic Dermatology, Orlando.

November

1-2—12th Annual Ophthalmology Clinical Conference, WVU Department of Ophthalmology, Morgantown.

3-7—American Society for Therapeutic Radiology and Oncology, Washington, D.C.

4-6—17th Southeastern Conference on High Blood Pressure, Louisville.

7-10—American Pain Society 10th Annual Scientific Meeting, New Orleans.

8-10—5th Annual Family Practice Weekend and Sports Medicine Conference, WV Chapter of American Academy of Family Physicians, MU Department of Family Medicine and Community Health and Division of Sports Medicine, MU School of Medicine, Huntington.

9-14—44th Annual Meeting of American Association of Blood Banks, Baltimore.

10-14—American Public Health Association, Atlanta.

14-17—National Kidney Foundation, Baltimore

15-19—The 3rd Annual Postgraduate Endocrine Update: Endocrine Cancers, Ohio State University, Columbus.

15-20—American College of Allergy and Immunology, New York City.

16—American Cancer Society, Atlanta.

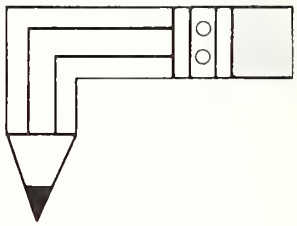
16-19—Southern Medical Association 85th Annual Scientific Assembly, Atlanta.

20-23—Association for Academic Surgery, Colorado Springs.

For More Information . . .

Contact the Journal for additional information about most of the above meetings. Call (304) 925-0342.

Poetry Corner



Autumn Fishing

A brigand cloud
Pokes its head over a wave
And blows its breath our way
Cold and biting
It closes coats, lifts skirts,
Numbs fingers till it hurts

The fish stop biting
And fishermen go home,
The waves start pounding
And the wind begins to moan
Birds going up wind
Can hardly make it
While those going down
Sail like a stone

Darkness comes quick
But there's ne'er a reason to doubt
It's a storm for the season
You had best watch out

But morning will come
And true to your wishing
Get up lazy bones
It's time to go fishing.

J. Paul Aliff, M.D.

Please address your submissions for Poetry Corner to: Stephen D. Ward, M.D., Editor, West Virginia Medical Journal, Box 4106, Charleston, WV 25364.

For excellent response in the treatment of duodenal ulcers...

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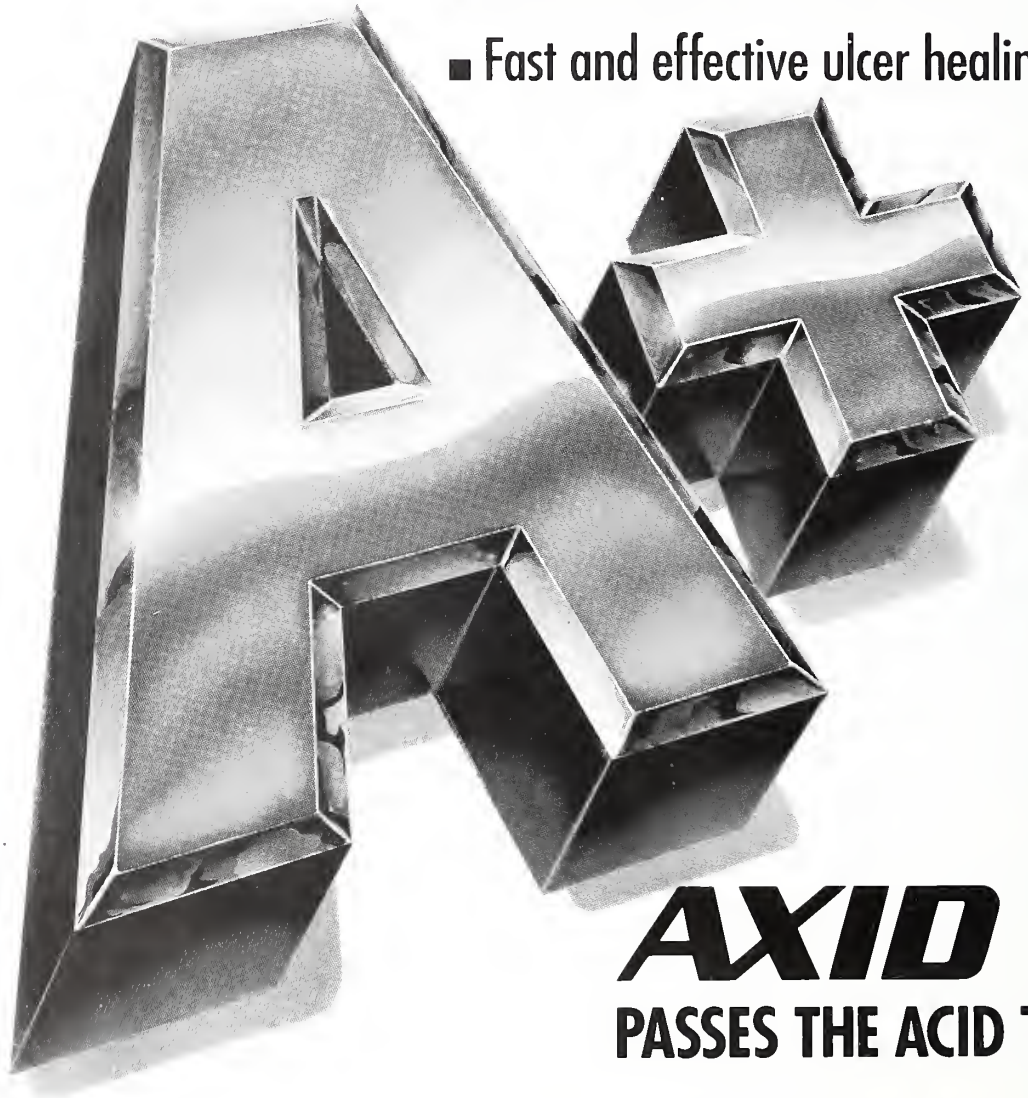

AXID

PASSES THE ACID TEST

*Most patients experience pain relief with the first dose.

See adjacent page for references and brief summary of prescribing information.

NZ-2943-B-149347

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AXID® (nizatidine capsules)

Brief Summary. Consult the package insert for complete prescribing information.
Indications and Usage: 1. *Active duodenal ulcer*—for up to 8 weeks of treatment. Most patients heal within 4 weeks.

2. *Maintenance therapy*—for healed duodenal ulcer patients at a reduced dosage of 150 mg h.s. The consequences of therapy with Axid for longer than 1 year are not known.

Contraindications: Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H_2-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H_2-receptor antagonists.

Precautions: *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix® may occur during therapy.

Drug Interactions—No interactions have been observed with theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,900 nizatidine patients and over 1,300 on placebo, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events were due to the drug.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H_2-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H_2-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis does not substantially increase clearance of nizatidine due to its large volume of distribution.

PV 2091 AMP
[091190]

References
1. Data on file, Lilly Research Laboratories.
2. *Scand J Gastroenterol.* 1987;22(suppl 136):61-70.
3. *Scand J Gastroenterol.* 1987;22(suppl 136):47-55.
4. *Am J Gastroenterol.* 1989;84:769-774

NZ-2943-B-149347

Additional information available to the profession on request.

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YOHIMBINE HCl

Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

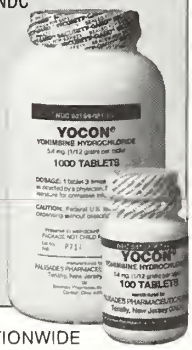
Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:
1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85



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WEST VIRGINIA UNIVERSITY HEALTH SCIENCES CENTER

Compiled from material furnished by the West Virginia University Health Sciences Center News Service, Morgantown.

Six Physicians Join WVU's Emergency, Surgical Services

West Virginia University has recently added six new staff members, who specialize in surgery or emergency care.

Vincente Cortes, M.D., formerly an attending physician in the Emergency Care Center at Jackson Memorial Hospital in Miami, has joined the surgery staff at WVU. He is an assistant professor of surgery in the section of trauma and critical care, and a staff surgeon for the Louis A. Johnson Veterans Administration Medical Center in Clarksburg, a WVU affiliate hospital.

A native of Bogota, Columbia, Dr. Cortes received his medical and surgery degree with honors from the National University of Columbia. He did a general surgery residency and fellowships in surgical critical care and trauma at the University of Miami School of Medicine, where he also received the Ellen Whiteside McDonnell Education Award.

Dr. Cortes' professional experience includes service as a rural physician and health care coordinator at San Antonio Hospital in Mitu, Columbia; work as a house staff physician at the Hospital Clinica El Bosque; and teaching in the bioclinical area at the Columbian School of Medicine Foundation in Bogota.

The plastic and reconstructive surgery section of the WVU Department of Surgery is expanding services with the addition of Daniel Stewart, M.D.

A native West Virginian from Mullens, Dr. Stewart did his internship and residency in general surgery at WVU from 1980-85. Before accepting his current position, he was a resident physician in the Divison of Plastic Surgery at the University of Missouri in Columbia, Mo.

Dr. Stewart formerly was assistant professor of general surgery, director of the surgical special care unit, director of the surgical stepdown unit, and acting director of the trauma surgery service, all at WVU.

New additions to the Emergency Department at WVU include Daniel S. Frame, M.D., Debra Paulson, M.D., and Lee Smith, M.D., J.D.

Dr. Frame is a West Virginia native from Sutton. He received his medical degree from the WVU School of Medicine in 1986. He did an internship at St. Thomas Medical Center in Akron, Ohio, and an emergency medicine residency at Kern Medical Center in Bakersfield, Calif. His experience includes Emergency Department service at Braxton County Memorial Hospital in Sutton, City Hospital in Martinsburg, and Sierra View District Hospital in Porterville, Calif.

Dr. Paulson came to the WVU Emergency Department from Waynesboro, Va., where she was a member of an emergency group practice. She was medical examiner for Waynesboro City and Augusta County in Virginia, and formerly was a flight physician in a Flight for Life program in Milwaukee.

Dr. Paulson received her M.D. from the University of Minnesota Medical School. She did internships at the Medical College of Toledo and the University of Minnesota Hospitals, and her emergency medicine residency at the Medical College of Wisconsin.

Dr. Smith, a native West Virginian from Charleston, received his M.D. from the Marshall University School of Medicine in 1982. He completed three years in a general surgery residency before entering private practice as chief of staff and director of emergency services at Wyoming General Hospital in Mullens, W.Va. He later became director of the Richwood Area Medical Center's Ambulatory Care Center.

His rural medicine experience includes service as staff physician in the emergency departments of St. Joseph's Hospital in Buckhannon and Greene County Memorial Hospital in Waynesburg, Pa.

Dr. Smith received his jurisprudence doctorate from the WVU College of Law in May 1991 and has been a clinical instructor in the Emergency Department since June 1991.

Juanito V. Chua, M.D., has been named chief of surgical services at the Louis A. Johnson Veterans Administration Medical Center. He is responsible for supervising residents of the WVU general surgery residency program serving rotations at the hospital.

Dr. Chua recieved his M.D. from the University of St. Tomas in the Philippines in 1962. He did his surgery residency at VA Medical Centers in White River Junction, Vt., and East Orange, N.J., and did an anesthesia residency at Mt. Sinai Medical Center in New York.

WVUH Names Two Vice-Presidents

John Brick, M.D., and Lucinda Ourant, R.N., have been named vice presidents of West Virginia University Hospitals.

Dr. Brick, a member of the faculty of the WVU School of Medicine since 1981, is WVUH's new vice president for medical affairs. A neurologist, Dr. Brick is an associate professor of medicine. Originally from South Charleston, he is a 1977 graduate of the WVU School of Medicine, and completed specialty training at WVU and at the Mayo Clinic. He is board-certified in neurology and EEG.

Ourant, who joined WVUH as a staff nurse in 1980, is vice president for nursing. She has been director of acute care nursing in the medical/surgical division since 1988.

Originally from Newark, Ohio, Ourant holds a bachelor's degree in nursing from Kent State University and a master's degree from WVU.

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MU School Of Medicine News

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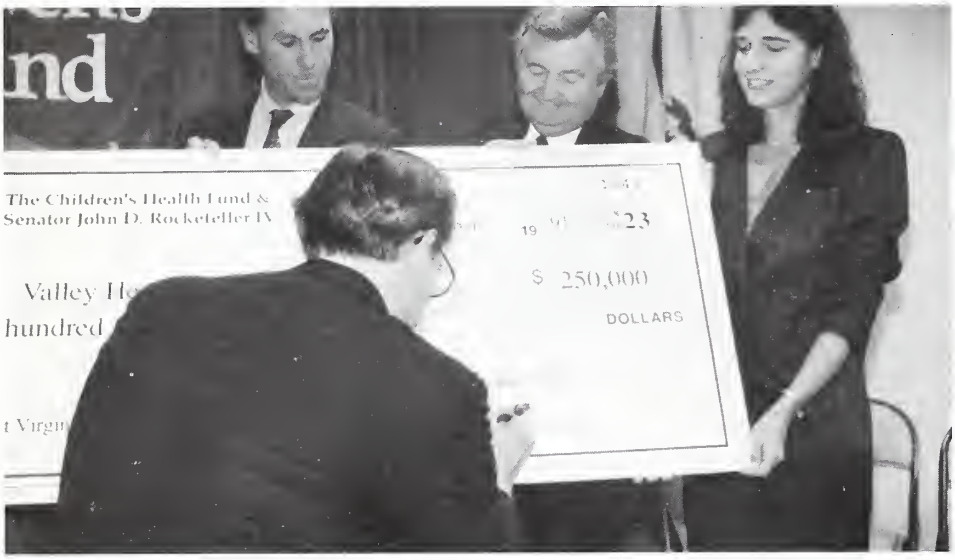
Compiled from material furnished by the Office of University Relations, Marshall University.

Mobile Pediatric Clinic Announced



Senator Jay Rockefeller signs a ceremonial check representing the money he and the Children's Health Fund have donated for a mobile pediatric clinic and its first-year operating costs. Helping to hold the check are Dr. Joseph Werthammer, chairman of Pediatrics at MU; A. Michael Perry, co-director with Senator Rockefeller of this new state project; and Dr. Patricia Kelly, associate professor of pediatrics at MU and the program's medical director.

Photo courtesy of Cabell Huntington Hospital

A mobile pediatric clinic will soon be traveling to rural areas of West Virginia through a partnership between Marshall's School of Medicine and Valley Health Systems, thanks to a grant from the Children's Health Fund and U.S. Senator Jay Rockefeller.

This new mobile pediatric clinic will use Valley Health clinics as starting points and make weekly half-day or full-day stops in small towns in Wayne, Lincoln, Mingo and Logan counties. With two exam rooms, an interview room, a small lab, a waiting area and state-of-the-art computer system, the mobile clinic is a fully-equipped physician's office.

Traveling teams will include a driver, clerk, nurse and provider — either a nurse practitioner, pediatrics resident, or family practice physician. To provide continuity of care, each community will have a regular team of providers which returns at each visit.

Dr. Patricia Kelly, associate professor of pediatrics at Marshall, will be the program's medical director. The School of Medicine also will provide specialty care and pediatrics residents for the program. Valley Health will coordinate the project with local community groups, provide family practice physicians and other provider and support staff, and offer 24-hour coverage through its physician call system. A. Michael Perry of Huntington and Senator Rockefeller will be co-chairman of the West Virginia project.

"We will provide comprehensive well-child care and also hope to reach teen moms and their children, children who have been seen in the emergency room, and children who have been discharged from the Neonatal Intensive Care Unit who have problems getting in for follow-up care," Dr. Kelly said. "The Pediatrics Department of Marshall passionately cares about the kids of West Virginia. We want them to receive quality health care, and to have access not only when the van is there but also when it is not. Hopefully, familiarizing residents with rural medicine will encourage them to set up practice in such areas themselves."

A transportation system is being arranged to help the rural patients get necessary subspecialty care.

Senator Rockefeller, who arranged for a $100,000 gift from an anonymous donor and gave $50,000 to the program himself, said, "We have to fight for and protect the future of our children. Lives are twisted and lost because people are too poor or too isolated — psychologically or geographically — from getting health care."

Dr. Irwin Redlener, co-founder and president of the Children's Health Fund, called the mobile vans "an immediate solution, a known solution" to children's health problems. "The challenge was to find the right homes for the vans. Finding the connection of Valley Health Systems and Marshall was incredible for us."

Steven Shattls, Valley Health Systems executive director, said, "The partnership between Valley Health and Marshall University Pediatrics Department is a model in both medical education and health-care service delivery that soon will be nationally known and envied."

Lederele Laboratories is a major corporate donor to the project.

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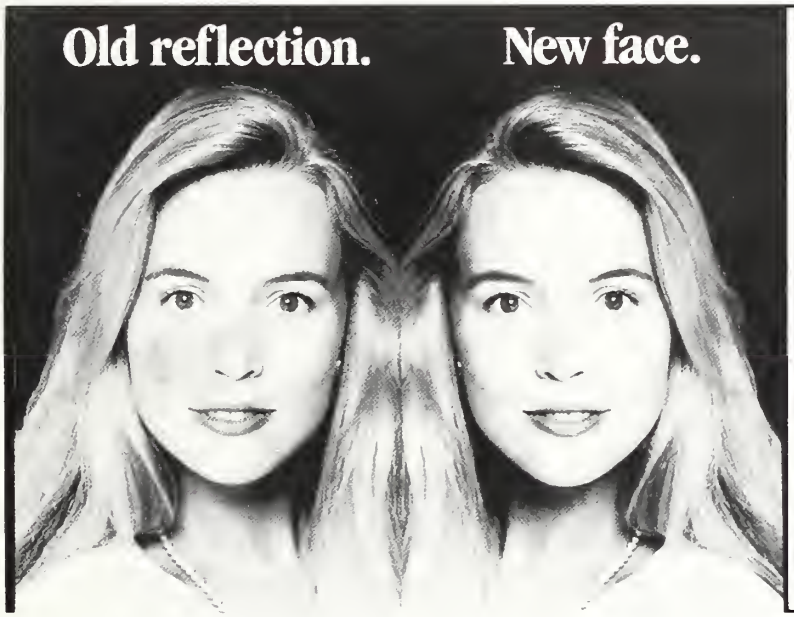

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Physicians

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Obituaries

Elpidio P. Carag, M.D.

Elpidio P. Carag, M.D., 52, of Beckley, died August 13, in a Beckley Hospital, following a short illness.

Born March 4, 1939, in the Philippines, Dr. Carag had been a physician in Beckley since 1975. He was a member of the WVSMA, Raleigh County Medical Society, Southern Medical Association, Philippine Medical Association and Philippine Medical Team.

Dr. Carag served in the Vietnam War for four years. He was a member of the National Rifle Association, Beckley Gun Club and the St. Francis DeSales Catholic Church.

Survivors include his wife, Fely M. Carag; a son, Nguyen Van Carag of Myrtle Beach, S.C.; three daughters, Sharone Carag of Morgantown, Mrs. Brian K. (Giovannie "Bunny") Meadows and Vladimire (Amire) Carag, both of Beckley; three brothers, Judge Rafael P. Carag of the Philippines, Johnny P. Carag and Engr. Ignacio P. Carag; a half sister, Mary Tuliao of the Philippines; and a grandson.

Leonard I. Hoke, M.D.

Leonard I. Hoke, M.D., of Nitro, died in June at the age of 88.

Born in Princeton, W.Va., Dr. Hoke was a graduate of Concord College and the Medical College of Virginia. He was a family practitioner who delivered more than 4,000 babies in his career.

A former chief of staff at Thomas Memorial Hospital, Dr. Hoke had been a member of the West Virginia State Medical Association since 1931. Dr. Hoke was also a member of St. Paul's United Methodist Church, Nitro Masons, Scottish Rite and Beni Kedem Shrine.

For 12 years, Dr. Hoke served on the Nitro City Council and he was also a former member of the Nitro City Park Board.

Survivors include his wife, Lucille Woodson Hoke; daughters, Barbara Lawson of Greenville, Tenn., Frances Jeranko of Costa Mesa, Calif., and Mary Stone of Lima, Ohio; nine grandchildren and 16 great-grandchildren.

Jack Leckie, M.D.

Dr. Jack Leckie

Jack Leckie, M.D., 74, president of the WVSMA from 1975-76, died September 7 at his home in Huntington.

Born in Toler, Ky., Dr. Leckie graduated from Marshall University and the George Washington University School of Medicine. He interned at the U.S. Marine Hospital in New Orleans.

A veteran of World War II, Dr. Leckie was a commander of a U.S. Navy landing craft during the D-Day invasion.

Dr. Leckie headed a group of Huntington physicians who started around-the-clock staffing of the emergency room at St. Mary's Hospital in Huntington, the first West Virginia hospital to offer the service. He became chairman of the Emergency Physicians' Group that started up July 1, 1966, and gave up his private practice to become the group's chairperson, a post he held for 20 years.

In 1971, the American College of Emergency Room Physicians was organized to accredit doctors in the practice of emergency medicine and Dr. Leckie was a delegate at the organizational phase.

Dr. Leckie was a past president of the West Virginia Chapter of the American Academy of Family Physicians and the Cabell County Medical Society. In addition to serving as WVSMA president from 1975-76, Dr. Leckie was also an alternate and then a delegate to the AMA House of Delegates.

In 1986, Dr. Leckie was named an honorary member of the American College of Emergency Physicians, which he helped pioneer with his work in Huntington. Dr. Leckie was also a member of the American Academy of General Practice and the American Academy of Family Physicians. He was 63-year member of First Presbyterian Church in Huntington and was a past member of the Greater Huntington Area Chamber of Commerce.

Survivors include his wife, Barbara Bartels Leckie; a son, J. Stephen Leckie of Lexington; two sisters, Mrs. Jean Stettler and Mrs. Katherine Eddins; and a brother, Don Leckie, all of Huntington.

(Please see related Editorial and Our Readers Speak on page 479.)

Tracy N. Spencer Jr., M.D.

Tracy N. Spencer Jr., M.D., of Sarasota, Fla., died in May at the age of 76.

Dr. Spencer was a graduate of the University of North Carolina and the University of Maryland School of Medicine. He interned and did his residency at Mercy Hospital in Baltimore.

A member of the medical staff at Thomas Memorial Hospital, Dr. Spencer was instrumental with Dr. Reuben Wohlford in helping to organize the Volunteer Chaplaincy Program and see that a chapel was built at the hospital.

Dr. Spencer served as the medical director at the Union Carbide Technical Center. He joined the WVSMA in 1944 and served as the chairman of the Medicine and Religion Committee from 1965-72.

Active in various Christian organizations, Dr. Spencer was a member of the Living Word Christian Center in Charleston.

Dr. Spencer was survived by his wife, Mary D. Spencer; sons Dr. Tracy N. Spencer III and Richard W. Spencer of Everett, Wash.; daughter Mary Royer of Portland, Ore., and seven grandchildren.

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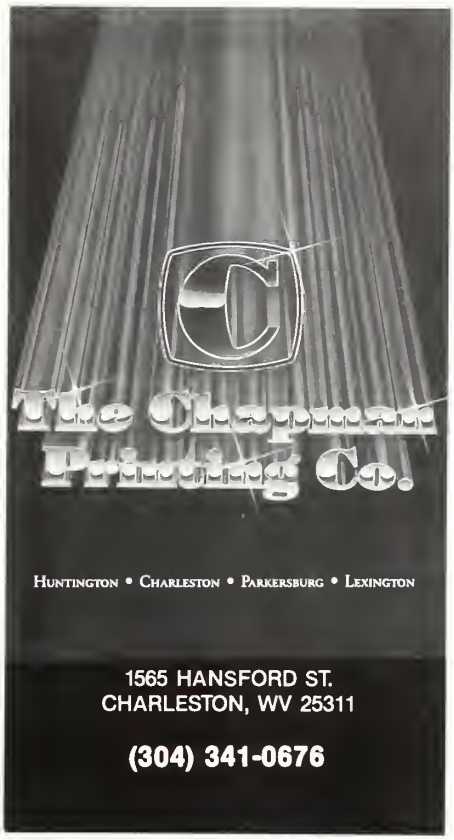

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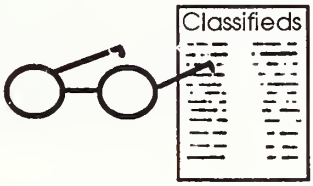

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BRIEF SUMMARY

Contraindications: Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digitoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°, 2°, 3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

4/11/91 • P91CA6143V

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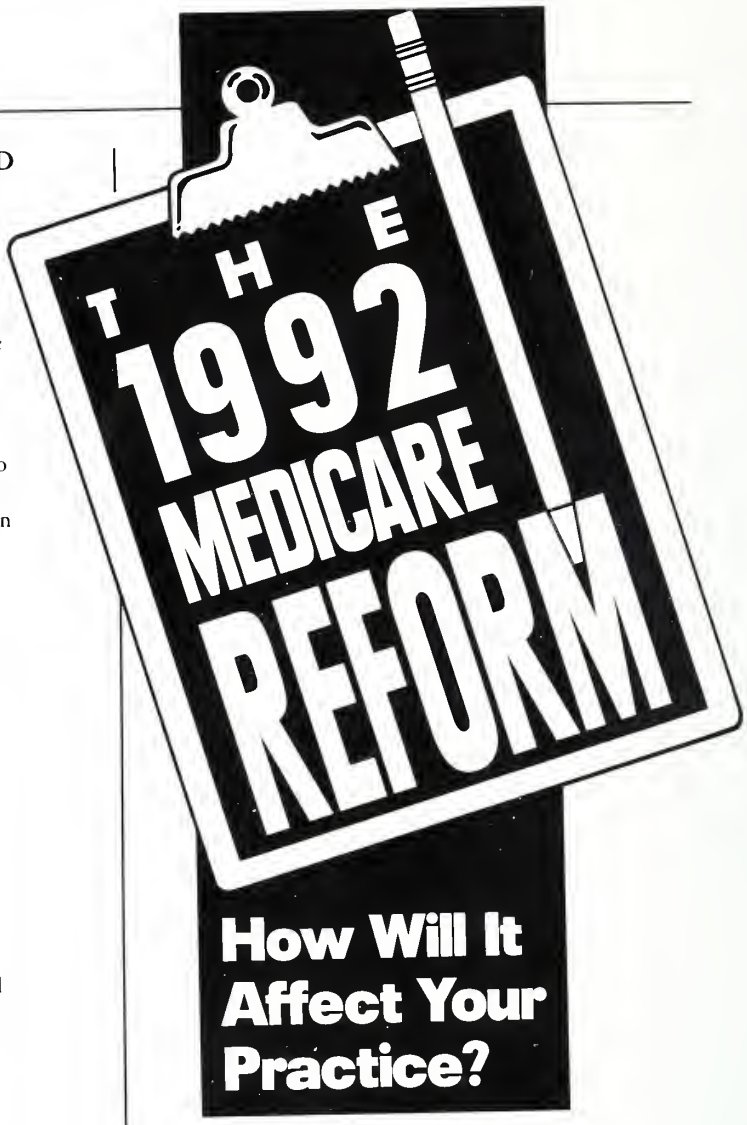

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Phil has also authored two Medicare texts: *The Doctor's Guide to Medicare*, and *Medicare in the 90's, a Medicare Workbook*. In addition, Phil serves as a columnist for *The Health Niche Advisor*.

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To register by phone or for more information Call Simpson & Osborne at (304) 343-0168.

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And not seek

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Front Cover

A squirrel enoys a snack on the lawn at the State Capitol in Charleston. Photo courtesy of *Stephen J. Shaluta Jr., West Virginia Division of Tourism and Parks.*

Family Physicians' Perceptions of Health Manpower Needs in West Virginia

STEPHEN L. SEBERT, M.D.
Associate Professor of Family Medicine, West Virginia University School of Medicine, Morgantown

Editor's Note: *This paper presents the results of a survey of West Virginia family physicians regarding their perceptions of the need for physicians and allied health personnel in their communities. It also addresses their perceptions of the advantages and disadvantages of practicing in West Virginia.*

Introduction

Recently, there have been conflicting reports on the health manpower needs of West Virginia. In fact, opinions differ so greatly on this subject, that much of the 1991 session of the Legislature was taken up with debate over the number and type of physicians needed in the state to adequately provide care, and how to retain medical school graduates to meet that demand.

Unfortunately, with all this controversy and the number of editorials written on this subject, the state's physicians have never been asked about their feelings. I feel family physicians can provide a particularly unique perspective on West Virginia's health manpower needs since they are often the portal of entry into the health care system. They care for the majority of medical problems themselves and refer others to consultants. Family physicians are usually very aware of the health care resources of their communities, and to what extent these resources are over or underutilized.

Methodology

To obtain the perceptions of family physicians on the needs for physicians and allied health personnel in their communities, I sent a letter and questionnaire (Figures 1 and 2) to every practicing member of the West Virginia Chapter of the American Academy of Family Physicians (WVAAFP). WVAAFP provided the mailing labels and helped sponsor the survey. The letters were sent in late March 1991 with unstamped return envelopes.

The 437 questionnaires were to be returned by May 1, and were tabulated by early June. No follow-up was done. There were 193 returned (44 percent) and responses included all but six of the 55 counties in the state. There were no responses from Clay, Gilmer, Hampshire, Jackson, Pendleton, and Wirt counties, so physicians were contacted in these counties by telephone in order to complete the study. There is no full-time practicing physician in Wirt County, so the county ambulance service was contacted to get information about that county. With the telephone interviews, all 55 counties were represented and the total number of respondents was 200 (46 percent).

Findings

Although the results are presented in detail in Tables 1 and 2, they may be summarized as follows: *(Percentages may not total 100 percent since some respondents did not answer every question.)*

- *168 (82 percent) of the respondents felt they were able to assess the health care needs of their community; 11 (5 percent) said no; and 22 (11 percent) were not sure.
- *86 (44 percent) said there is a physician shortage in their community; 44 (21 percent) said no; and 8 (4 percent) were not sure.
- *137 (67 percent) said there is a shortage in certain specialties; 23 (11 percent) said no; and 12 (6 percent) were not sure.
- *In most cases, the community was considered to be the county.
- *In 37 of the 55 counties represented, the majority of respondents said there was a physician shortage, and 50 counties have a shortage in certain specialties.
- *There does not appear to be a perceived physician shortage in Brooke, Cabell, Gilmer, Greenbrier, Jackson, Kanawha, Logan, Mercer, Monongalia, Ohio, or Pendleton counties, but all of these counties could use more physicians.
- *The statewide totals of the number of physicians needed were:

Family Practice 69-150
Obstetrics-Gynecology 47-104
Pediatrics 23-62
Internal Medicine 18-74

Figure 1. Letter Accompanying FP Questionnaire

March 14, 1991

Dear WV Family Doctor:

We keep hearing about the health manpower shortage in West Virginia, but I have not seen any objective data on its magnitude. I think that we as family physicians have a better handle on the health care needs of our communities than anyone else, but no one has asked us for our input.

With the help of the WVU School of Medicine, Department of Family Medicine, and the WVAAFP, I am conducting a survey of all family doctors in the state. Please complete and return the enclosed questionnaire by May 1, 1991. Your response is vital!!!

The results will be published and used to identify our needs and help formulate a plan of action. Hopefully, this will result in a cooperative program by all of the health care training institutions in West Virginia.

Sincerely,
Stephen L. Sebert, M.D.

Psychiatry 18-44
Ear, Nose and Throat 13-25
Orthopedics 26-53
General Surgery 12-34
Radiology 6-16
Anesthesiology 7-23
Emergency Medicine 31-49
Urology 4-12
Cardiology 10-28
Gastroenterology 10-19
Neurology 7-16
Ophthalmology 5-8
Allergy and Immunology 1
Dermatology 1
Neurosurgery 4

*51 doctors in 27 counties are actively looking for an associate.
*95 doctors (48 percent) in 34 counties have seriously considered leaving the state.
*Many who are looking for an associate are considering leaving themselves.

*The greatest problems mentioned with practicing in the state and the number of respondents were:

Reimbursement 65
State government 51
Malpractice climate 43
Economy 38
Insurance companies 12
School systems 5
Lack of patient education 4
OB coverage 2
Access to care 2
Isolation 2
Perceived image of state 2
Lack of easy referral 1
Greed 1
Social despair in the population 1
Unreasonable perception by WVSMA of political realities 1
Difficulty recruiting associate 1
Lack of quality academic referral center 1
Poverty 1

*The greatest advantages to practicing in West Virginia and the number of respondents were:

The people 51
Quality of life 42
It's home 25
Natural beauty 14
Family 12
None 11
Environment 9
Low crime rate 7
I'm needed 6
Ability to utilize skills which are more restricted in other states 6
Outdoor recreation 4
Small size 2
Climate 2
Good educational programs 2
Serenity 2
Low cost of living 2
Service to others 1
Almost heaven 1
Lack of AIDS 1

*The statewide totals for allied health personnel were:

Registered Nurses 335-971
Licensed Practical Nurses 312-724
Physicians' Assistants 40-104
Pharmacists 16-39
Dentists 14-33
Midwives 13-47
Nurse Practitioners 24-54
Medical Technologists 51-139
Radiologic Technologists 8-10
Physical Therapists 49-69
Certified Registered Nurse Anesthetists 1

(Radiologic technologists and certified nurse anesthetists were not included on the questionnaire and were "write-ins.")

Figure 2. WV Health Manpower Needs Questionnaire

Please circle your response.

Do you feel you are able to assess the health care needs of your community? yes no not sure

Is there a physician shortage in your community? yes no not sure

In certain specialties? yes no not sure

Define what you consider your community as used above:
town county your hospital other _____

How many more of the following do you estimate that your community needs:
Family Practice_____ Obstetrics_____ Pediatrics _____
Internal Medicine _____ Psychiatry _____ ENT _____ Orthopedics _____
General Surgery _____ Radiology _____ Anesthesiology _____ Emergency _____
Medicine_____ Urology_____ Cardiology_____ GI_____
Neurology _____ Ophthalmology _____ Other(s) _____

How many more of these Allied Health Care Professionals does your community need?
RNs _____ LPNs _____ PAs _____ Pharmacists _____ Dentists _____
Midwives_____Nurse Practitioners (indicate specialty(s)_____
Physical Therapists _____ Med. Techs _____ Other _____

Is your community capable of supporting the additional professionals you indicated are needed? yes no not sure

Are you now actively looking for an associate? yes no

Have you seriously considered leaving the state? yes no

If yes, what were the reasons you considered leaving?
Economy Reimbursement SB-576 Other _____

Where would you go?_____

What do you consider to be the single greatest problem with practicing in WV?

_____

What is the greatest advantage to practicing in WV?

_____

Comments:

_____

Summary

West Virginia family physicians feel that they are able to assess the health care needs of their communities. There is a need for more physicians in all of the major specialities in West Virginia, but the largest numbers of physicians are needed in family practice and obstetrics. More registered nurses and licensed practical nurses are needed than any other health care professionals.

Twenty-five percent of the respondents are actively recruiting associates, and 48 percent have seriously considered leaving, or are leaving West Virginia. The most commonly cited reasons for leaving

TABLE 1. Number and Type of Physicians by County

	#RES	SHRT	CERT	FP	OB	PED	IM	PSY	ENT	ORTH	GS	RAD	ANES	ER	URO	CAR	GI	NEU	OPHT	ALLG	DERM	NS	ASSC	LEAV	SUPP
Barbour	1	Y	Y	3	1	1	1							2										1	NS
Berkeley	4	Y	Y	3-5	1-3	1-2	2	1-3	1	2-3	0-1	1	1	1-3		1	1	1	1	1			1Y	2	Y
Boone	1	Y	Y	3	3	2	1	2																	
Braxton	1	Y	Y	1			1	1pt		1		1pt		1										1	Y
Brooke	2	N	Y		2-3			1	1						1									1	Y
Cabell	8	2Y5N	6Y1N	5	3-5	3	5-8	1	0-2	0-4	0-4	0-2				0-2	2	1				1	6Y	3	Y
Calhoun	1	Y	Y	1							1			2									1		Y
Clay	1	Y	Y	3	2	1	1	2	1pt	1	1	2	1-2	2	1	1	1	1	2					1	N
Doddridge	1	Y	Y	1																			1		NS
Fayette	7	Y	Y	1-4	1-3	1-2	0-2	1-2	0-1	0-1	0-2			0-3		0-2	0-1	1					3	4	Y
Gilmer	1	N	N																						Y
Grant	2	Y	Y	1-2				1		1		1			1								1	1	Y
Greenbrier	5	1Y4N	Y4N		1-2			1	1	1							1						1	2	Y
Hampshire	1	Y	Y	2	1	1								1									1		Y
Hancock	1	Y	Y	2				2	1	1								1	1						Y
Hardy	1	Y	Y	1																				1	NS
Harrison	12	10Y	10Y	1-15	1-4	1-3	0-6	0-3	0-2	0-3	0-3	0-6	0-5	3-5			0-1						3	7	Y
Jackson	1	N	Y		1	1				1				1											Y
Jefferson	6	5Y	Y	0-2	0-4	0-1	0-1	0-1	1	0-2				0-1		0-2	0-1	1					1	4	Y
Kanawha	22	8Y	14Y	0-10	2-20	0-15	0-15			5		0-2	0-4			0-5		0-2					3	11	15Y
Lewis	2	Y	Y	1	1	1					1													1	Y
Lincoln	1	Y		6																					NS
Logan	6	2Y	3Y	0-5	2	0-2		2	0-2	2				0-2		0-2	0-2					1		4	Y
Marion	6	4Y	Y	1-3	0-1		1-3	0-1		1	1			2		1	1						2	3	Y
Marshall	2	Y	Y	2	1	0-1	0-1	0-4		1						0-1			0-1						Y
Mason	2	1Y	2Y	2	1-2			1		1			20-1			1	1	0-1						2	Y
McDowell	2	N	Y		1					1	1					1									NS
Mercer	6	2Y	Y	1-8	2-3	1-2	0-2			0-2	0-2		0-1	0-2		1-2	0-1						3	4	3Y
Mineral	4	Y	Y	1-6	2	1-2	0-2	0-1		0-2				0-2	0-2	0-1			0-1				2	2	Y
Mingo	2	Y			1-2																				
Monongalia	14	2Y	5Y	0-3	0-2	0-2	0-5		0-1	0-5	0-2				0-3								3	6	Y
Monroe	1	NS	NS	1				1		1				3										1	NS
Morgan	2	Y		1-3	0-1				1pt	1pt	1							1pt	1pt				1	1	Y
Nicholas	4	2Y	2Y	0-4	1-2	0-1		0-1			0-1		0-1												NS
Ohio	15	3Y	12Y	0-2	3-8	0-3	0-5	1-3		0-2			0-2					0-3					2	10	12Y
Pendleton	2	N	c		c		c	c																	Y
Pleasants	1			1																					NS
Pocahontas	2	1Y	1Y	2	1	1	1			1	1		1										1	1	Y
Preston	7	5Y	Y	2-3	1	0-1		0-1		0-1			0-1	0-1	0-1		0-1						3	5	Y
Putnam	2	Y	Y	2-3	1-2	1-2				1-2					0-1								1		Y
Raleigh	9	2Y	6Y	0-5	0-5	0-2	0-1	0-1	0-1	0-1								0-2				2	1	4	Y
Randolph	3	2Y	Y	2	1-2	0-1	0-2	1-2	0-1	0-1	0-1			2							1		1	1	Y
Ritchie	1	Y		1																			1	1	N
Roane	1	N	Y	2	1				1		1-2			1		1							1	1	Y
Summers	2	Y	Y	2	2	1	1-4		1		2		1			1							1		NS
Taylor	2	1Y	Y		1	1			1				1										1	1	Y
Tucker	1	N																							
Tyler	1	Y		1-2			1pt		1pt	1pt	1pt			1-2											Y
Upshur	5	Y	Y	1-3	1-2	0-1	0-2	0-2		1							0-1							3	Y
Wayne	1	Y	Y	2-3	1			1		1	1				1									1	N
Webster	1	Y	N	1																					N
Wetzel	2	1Y	1Y	2	1	1		1		1															Y
Wirt	1	Y	N	1																				1	Y
Wood	7	4Y	6Y	2-1	2-5	2-4	1-5	2	1-2	1-3	1-5		2	10-	2	1-3	2-3	0-1	0-1				5	3	Y
Wyoming	1		Y	1		1	2			1	1	1			1	1	1								NS
# Counties	55	37	50	46	38	30	24	26	18	31	20	8	13	19	9	17	15	11	7	1	1	3	27	34	37
Total	200	37	50	69-150	47-104	23-62	18-74	18-44	13-25	26-53	12-34	6-16	7-23	31-49	4-12	10-28	10-19	7-16	5-8	1	1	4	51	95(48%)	

RES—Number of respondents
SHRT—Shortage of physicians
CERT—Shortage of physicians in certain specialties
FP—Family practitioners
OB—Obstetricians-gynecologists
PED—Pediatricians
IM—Internal medicine specialists
PSY—Psychiatrists
ENT—Ear, nose and throat specialists
ORTH—Orthopedic specialists
GS—General surgeons
RAD—Radiologists
ANES—Anesthesiologists
ER—Emergency physicians
URO—Urologists
CAR—Cardiologists
GI—Gastroenterologists
NEU—Neurologists
ALLG—Allergists
DERM—Dermatologists
NS—Neurosurgeons
ASSC—Looking for an associate
LEAV—Considering leaving the state
SUPP—Can the county support the professionals needed?
Y—Yes N—No NS—Not sure
PT—Part-time
C—Consultant

are inadequate reimbursement, the state's economy, SB-576, lack of tort reform, and state government in general.

The greatest advantage given to practicing in the state are its people, the quality of life, and home and family. In addition, the greatest problems are reimbursement, state government, the malpractice climate and the state economy.

The survey shows that state government needs to show a good faith effort to enact tort reform to improve relations with physicians. The threat of losing more physicians is real and must be addressed. Improving the climate for the practice of medicine is a viable solution to West Virginia's manpower problems.

There is also a need to continue all present health care professional training programs. More emphasis should be placed on recruitment and retention of nursing students. There is expressed support for nurse midwives, nurse practitioners, and physicians' assistants all working under the supervision of physicians. The finding that home and family are frequently listed as advantages to practicing here indicates recuitment and nurturing of students from underserved areas should be increased.

There has recently been some improvement in the relationship between state government and the physician community. This cooperative spirit must continue to be strengthened and supported.

Special Note: *A county-by-county summary of the results of this study is available by writing Dr. Sebert at the Department of Family Medicine, WVU School of Medicine, Morgantown, WV 26505.*

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TABLE 2. Number and Type of Allied Health Providers Needed by County

	RN	LPN	PA	PHAR	DEN	MW	NP	SPNP	MT	RT	PT	CRNA
Barbour	5	5	3	2	1	1			2			
Berkeley	10-20	30				1-2			3-5		3-5	
Boone											3	
Braxton	2-3		1						1-2	1-2		
Brooke						2	2	FP				
Cabell	50	20	5-10			1-3	10				10	
Calhoun												
Clay	15-20	5-20	2-3	2	1-2	1-2	1-2	OB	10-15			
Doddridge												
Fayette	10-100	10-20		0-2		1-2			3		1	
Gilmer												
Grant	5-10	5-10							1-2			
Greenbrier	10	20							2-3		2-3	
Hampshire			2			1	1	FP				
Hancock												
Hardy	1	1	1		1				1		1	
Harrison	5-50	10-20	1			0-5	0-3	FP/ER	2-3		2-4	
Jackson	Y											
Jefferson	5-10	5-10							0-3		1-2	
Kanawha	12-200	0-200	0-20				0-10		0-50		0-10	
Lewis												
Lincoln	3	3	2	1		1	1		1		1	
Logan	15-20				0-4	0-2	0-3				2-3	
Marion	5	2	3				2				1	
Marshall												
Mason	6-10								0-2		0-1	
McDowell					1				2	2		
Mercer	12-20	6-20	2-6							2		
Mineral												
Mingo												
Monongalia	10-50	50				0-3	0-5		10			
Monroe			1									
Morgan	8	10	1	2	1		1-2	FP	3		1	
Nicholas	5-10	5-10							2	2		1
Ohio	20-30	20-30	2-10	5	0-10	0-2	0-2	FP/PED			5-10	
Pendleton	10-20	10-20	1	1			1	FP/OB	1		1	
Pleasants			1									
Pocahontas	5	6	3			1					1	
Preston	6-15	2-20	1-6	1					3-5			
Putnam	15	10										
Raleigh	15-20	30-50	0-15			0-15			1-15			
Randolph	10	10	4			2	2-4	OR				
Ritchie												
Roane	12					1-2	1-2		3-4			
Summers	5	5										
Taylor	4	2	2				1		0-2	1	1-2	
Tucker					1-2							
Tyler												
Upshur	10	0-10				0-2	0-2	FP	0-3		0-1	
Wayne				2-3	5					2-3		
Webster	10		2	1	1-2				1		1	
Wetzel	10	10			2							
Wirt												
Wood	24-200	20-100	0-6	0-20	0-2						1-6	
Wyoming							1		1		1	
# per county	35	29	23	11	11	17	18		24	5	23	1
Total	335-971	312-724	40-104	16-39	14-33	13-47	24-54		51-139	8-10	49-69	1

RN - Registered nurses
LPN - Licensed practical nurses
PA - Physicians' Assistants
PHAR - Pharmacists
DEN - Dentists
MW - Midwives
NP - Nurse practitioners
SPNP - Specialty of nurse practitioners
MT - Medical technologists
RT - Radiologic technologists
PT - Physical therapists
CRNA - Certified registered nurse anesthestists
Y - yes (no specific number given)
FP - Family practice
FP/ER - Family practice and emergency room
FP/PED - Family practice and pediatricians
FP/OB - Family practice and obstetricians
OR - Operating room

The Patient Self-Determination Act: Benefit or Burden?

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Editor's Note: *The opinions expressed in this article are Dr. Moss' and should not be taken to necessarily represent those of the Henry J. Kaiser Family Foundation and Pew Charitable Trusts who help support the Center for Health Ethics and Law.*

Introduction

The Patient Self-Determination Act becomes effective December 1, 1991, and it applies to all health care institutions which receive Medicare or Medicaid payments. The act will have a significant impact on the way physicians practice medicine.

Will it impose one more burden on physicians from the federal bureaucracy or will the act lead to a significant benefit in patient care?

What Does the Act Say?

This act requires health care institutions which treat Medicare and/or Medicaid patients to provide written information to their patients about their rights to make health care decisions and complete advance directives. These institutions are expected to maintain policies respecting these patients' rights and to document their advance directive status -- whether or not they have a Living Will and/or a Medical Power of Attorney -- in the medical record.

In West Virginia, institutions will be required to comply with the West Virginia Natural Death Act and the Medical Power of Attorney Act, and they are not allowed to condition treatment to patients based on whether or not patients have completed an advance directive. There is also the additional requirement that these health care institutions educate their staff and their community about advance directives.

It is clear that the purpose of this act is to promote patients' rights, especially patients' rights to control their health care after they have lost the ability to make decisions by providing advance directives to their physicians and health care institutions. Since the main thrust of this act is to promote wider use of advance directives in patient care, it is worthwhile to consider the advantages, disadvantages, and limitations of the West Virginia Living Will and Medical Power of Attorney to assess the likely effect of this Act's implementation.

Advance Directives: Advantages and Disadvantages

The West Virginia Living Will is a written, legal document which must be executed by a patient while he/she has the capacity to make decisions, and which only goes into effect when that ability is lost. The Living Will is applicable only when the patient is terminal or in a persistent vegetative state. It states the patient's wish to refuse life-prolonging treatment when he/she is in such condition and to die a natural death with comfort.

There are three main disadvantages to the Living Will. First, it applies only to patients who are terminal or in a persistent vegetative state. It does not apply to other patients who may be chronically, but not terminally ill, and who might want to refuse life-prolonging procedures.

Secondly, the Living Will primarily pertains to the refusal of medical treatments. It was not designed to allow patients to request some treatments and to refuse others.

In addition, the other main disadvantage to the Living Will is that it makes no provision for the patient to designate a proxy decision maker, so there is no one designated to ensure that the provisions of a patient's Living Will are honored.

The West Virginia Medical Power of Attorney is a written, legal document which allows a patient of sound mind to designate a proxy decision maker, called a representative, to make decisions for him/her in the event he/she becomes incapable of doing so. This representative is authorized under law to give, withhold, and withdraw consent for any and all medical and surgical procedures and has the authority to request information and make decisions that the patient would have had.

The Medical Power of Attorney also allows the individual to specify exact instructions with regard to his/her future health care and to place limitations on the power of the representative. Just like the West Virginia Living Will, there are also three disadvantages to the Medical Power of Attorney.

First of all, few patients have completed one. The Patient Self-Determination Act was passed to increase patients' awareness about the use of this document.

Secondly, the patient's representative in the Medical Power of Attorney must know the person's values and wishes to be able to make good decisions for that individual. If the patient has not had a serious conversation with their designated representative and successor representative, the quality of the decisions made for that patient may suffer.

The third disadvantage of this document is the fact that people cannot exactly anticipate what future illnesses they might have. Therefore, a representative's knowledge of what the patient would have wanted in an unforeseen circumstance might be incomplete. In these situations, the Medical Power of Attorney Act calls for the representative to make the decision for the patient based on an assessment of the patient's best interests.

Which Advance Directive is Better?

Physicians are likely to be asked by their patients whether a Medical Power of Attorney or a Living Will is better. The Guardianship Task Force of the State Department of Health and Human Resources has concluded that the Medical Power of Attorney is a better document for the following reasons:

(1) The Medical Power of Attorney is more flexible and is not restricted to patients in certain conditions as the Living Will is;
(2) The representative named in the Medical Power of Attorney can make decisions about the current situation incorporating the information provided by the physician at the time;
(3) The Medical Power of Attorney allows for consent to some life-prolonging treatments and refusal of others, whereas, the Living Will allows for only refusal of treatments; and
(4) There is a much better chance of the patient's wishes being followed if there is a representative there to state the patient's preferences as opposed to the Living Will, which the physician must read and interpret.

Clinical Experience with Advance Directives

The clinical experience with advance directives also indicates the extent of their usefulness and their limitations in patient care. For many years now, one advance directive that physicians have routinely sought from patients is a directive with regard to resuscitation status. If the patient would not want cardiopulmonary resuscitation (CPR) in the event of a cardiac arrest, the physician can learn this information in advance and write a "Do Not Resuscitate" order.

One limitation to patients being able to assert their right to make decisions about resuscitation was highlighted by a study of "do not resuscitate" orders at the Beth Israel Hospital in Boston (1). In this study of over 300 patients for whom do not resuscitate orders were written, 89 percent of the patients had the ability to make decisions when they were admitted; however, only 22 percent of the patients participated in the decision. The reason for this was that the do not resuscitate decision was made on the average nine days after admission and these authors concluded that if the goal is to have patients participate in such decisions, physicians must ask patients their preferences early in the admission while they still have the capacity to make their own decisions.

Physicians sometimes think they know their patients' preferences with regard to resuscitation without asking them. Many studies now indicate that this is not always the case. In a study by Bedell, 24 patients who had undergone CPR were asked after the fact whether or not they would have wanted it. Their physicians were also asked whether or not they thought their patient would have wanted CPR. One third of the patients who were resuscitated had not wanted CPR, and their physicians had assumed that they had. This study indicates the importance of physicians obtaining an advance directive from their patients regarding CPR (2).

There is also the potential limitation that even if they are completed, advance directives may not be followed. In a study by Danis and her colleagues of nursing home patients who had completed advance directives, she found that patients were more likely to receive treatment consistent with their wishes if the advance directive was not present in the chart. Her study, discovered that the patient's directives were more likely to be followed in a hospital than in a nursing home. The authors concluded that the orientation of hospitals toward more aggressive treatment may have explained this outcome (3).

Another possible limitation of the Medical Power of Attorney is if the patient and his/her representatives have not discussed the patient's wishes. In a study by Uhlman and colleagues, spouses thought that their husband or wife would have preferred resuscitation and mechanical ventilation significantly more often than they did. In this same study, physicians thought that significantly fewer of their patients would have wanted CPR and mechanical ventilation than they did (4). This report and others show similar findings and indicate the fallacy of depending on close family members and physicians to make decisions for patients if they have not had discussions with these patients about their values and wishes for health care.

Physician and Patient Attitudes

Despite these mixed experiences with the use of advance directives in patient care, several studies document that patients and physicians report positive attitudes toward these documents. In a study of medical outpatients and the general public in Boston, Emanuel and colleagues found that over three-quarters of patients want a proxy decision maker for themselves, and approximately two-thirds of patients and the public wanted to discuss with their doctor their preferences with regard to life-sustaining treatment (5).

Since patients and the public had such a positive attitude toward advance directives, the investigators asked the patients what barriers they perceived to the use of advance directives in their care. The most commonly reported barrier was the patients' expectation that their doctor should take the initiative to discuss advance directives with them.

Similarly, in a study of elderly North Carolinians, 81 percent wanted to discuss end-of-life care with their physician. Fifty-nine percent wanted to have these discussions when they were well or at a routine visit as opposed to at the time of hospitalization. Only

7 percent of patients wanted their physicians to make decisions for them and of the 75 patients studied, none had signed a Living Will and only 8 percent had discussed terminal care with their physician. In the few cases where a discussion of terminal care had occurred, the patient had initiated the discussion in over half the instances. In addition, only 45 percent of the patients had discussed their wishes with regard to end-of-life care with a spouse or other family member (6). Thus, these studies demonstrate that patients want to have these discussions with their physicians and family members, but that usually these discussions have not occurred.

The attitudes of internists and family physicians in Arkansas towards advance directives have been reported by Davidson and colleagues (7). Eight-nine percent of physicians agreed that advance directives are an effective way for patients to influence their medical treatment, and 93 percent agreed that honoring a patient's request to withhold "heroic" treatment is more important than prolonging life. Eight-seven percent said that patients and families react positively to initiation of advance directive discussions. However, fewer than one-third of the physicians had discussed advance directives with more than 10 of their patients.

Physicians' Discussions with Patients

The studies mentioned in the previous section suggest that patients would be more satisfied with their care if they had the opportunity to discuss their values and preferences for life-sustaining treatments with their physicians. They also document that most physicians, despite their positive attitude toward advance directives, have not had discussions about them with their patients. An increasing number of articles in the medical literature have encouraged physicians to initiate such discussions with their patients. Marcia Angel, deputy editor of *The New England Journal of Medicine,* in her editorial on respecting the autonomy of patients wrote: "Recent surveys have shown that most people whether well or seriously ill, wish to be informed of their condition and to participate in medical decisions ... What does the patient want? Ask him." (8).

Similarly, Lo and colleagues have written that "most patients would like physicians to initiate discussions (about advance directives). Physicians should encourage competent patients to give advance directives, preferably written directives that both appoint a surrogate and indicate what treatments the patients would want" (9).

Some have suggested that these discussions become a part of routine medical practice. Wanzer and his colleagues have written: "Nevertheless, as a matter of routine, physicians should become acquainted with their patients' personal values and wishes and should document them just as they document information about medical history ... Such discussions and the resultant documentation should be considered a part of the minimal standard of acceptable care" (10).

Finally, failure of physicians to learn their patients' preferences and to honor them may lead to legal repercussions. Physicians who do not honor patients' wishes to forgo life-sustaining treatment may face charges of malpractice, battery, the intentional infliction of emotional distress, and violation of the common-law and constitutionally-based right to refuse medical treatment (11).

Burdens and Benefits of the Patient Self-Determination Act

What are the possible burdens that might result from the implementation of this act?

First, there is no doubt that it will result in more paperwork for health care institutions and physicians. Second, if patients are informed of their rights in an abrupt, insensitive way, it may cause unnecessary anxiety and fear. Third, as previously described, the completion of a Living Will or a Medical Power of Attorney, does not necessarily lead to the patient's wishes being followed.

Despite these potential burdens, there are substantial benefits that might be derived from the implementation of the Patient Self-Determination Act for patients, families, physicians, other health care personnel and society. Patients who complete a Medical Power of Attorney will be able to name a proxy decision maker of their choice and to specify their preferences for future health care. Families will be relieved of guilt and anxiety-provoking decisions about their family members, and they will be reassured that they are fulfilling their familial responsibility to care for their loved one when the patient's advance directives are followed.

In addition, physicians will benefit because the Medical Power of Attorney will designate for them a person with whom medical decisions can be made if the patient no longer has the capacity for making decisions. This aspect of the Medical Power of Attorney is especially important since physicians will no longer have to achieve a consensus of sometimes geographically-dispersed and dysfunctional family members. Physicians are reassured that they are doing what the patient would have wanted when they may be directed to do less than everything possible. Also, physicians are granted legal immunity when they follow the patient's wishes as stated in an advance directive. Other health care personnel and health care institutions benefit from advance directives for the same reasons.

Finally, advance directives promise to be a benefit to society. If patients complete advance directives, they should receive only the care they would want which is often less than what they are actually given. For example, evidence in the case of Nancy Cruzan documented that she would not have wanted the over $800,000 in medical care that she received to keep her alive in a persistent vegetative state. There would be a substantial savings for society in health care costs if expensive, life-sustaining treatments are limited to patients who are known to have desired them.

Conclusion

The Patient Self-Determination Act has the potential to significantly improve patient care to the extent that it leads to serious conversations about desired future health care between patients, their families and

physicians. Since patients are often reluctant to initiate these discussions with their physicians, physicians need to take the initiative in helping patients plan for end-of-life care. Due to the fact that patients under the stress of hospitalization are often not able to think very clearly about such issues, physicians' discussions with patients about these matters should ideally take place prior to serious illness and the need for hospitalization.

To promote these discussions in the outpatient setting, physicians should place copies of the West Virginia Living Will and Medical Power of Attorney forms in their waiting rooms. With these documents, they can also provide instruction sheets on how to complete them and booklets on commonly asked questions regarding these forms. *(Copies of these forms and booklets are available free through the WVSMA.)*

Ethics and the law have now evolved to the point that physicians' knowledge of their patients' values and preferences with regard to life-sustaining treatment is part of the standard of care for the practice of medicine.

Acknowledgement

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Parovarian Cystadenocarcinoma of Low Malignant Potential

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Abstract

Malignant parovarian tumors are rare, with only 20 cases previously reported. Only eight of these were cystadenocarcinomas of low malignant potential and only two had both mucinous and serous components. In this article, we report the third case of a parovarian cystadenocarcinoma with both serous and mucinous components -- A 26-year-old female who was treated by conservative surgery and later carried a pregnancy to term. Prognosis and management of these lesions are discussed.

Introduction

Epithelial ovarian carcinomas of low malignant potential comprise approximately 15 percent to 25 percent of all epithelial ovarian cancers (1). Parovarian malignancies, however, are far less common with only 20 patients previously reported (2,3). Eight of these have been cystadenocarcinomas of low malignant potential. Only two previous cases of mucinous and serous components in a low malignant potential parovarian carcinoma have been described.

This article describes the third case of a parovarian cystadenocarcinoma of low malignant potential with both mucinous and serous components. Due to the rarity of this lesion, it is suggested that these parovarian cystadenocarcinomas of low malignant potential be treated similarly to their ovarian counterparts.

Case Report

A 26-year-old white female (Gravida II, Para I, Ab 0) with LMP on September 16, 1988, was initially seen on November 7, 1988 for an obstetrical exam, appearing to be too large for this stage of her pregnancy.

A subsequent ultrasound showed an empty gestational sac with a cystic left adnexal mass measuring 6.1 cm. x 6.1 cm. x 6.2 cm. and a cystic right adnexal mass measuring 4.4 cm. x 4.4 cm. x 5 cm. She did not have a D & C and beta HCG levels showed spontaneous return to normal by nine days later.

At the time of her next examination, ultrasound again revealed the presence of adnexal masses. She suppressed use of birth control pills for one month, but follow-up ultrasound still showed the previously noted cystic masses.

The patient underwent an exploratory laparotomy about a month later and was noted to have a 7 cm. x 6.5 cm. x 5 cm. cystic mass within the left mesosalpinx totally separate from the ovary. The left tube was stretched over the cystic mass and distorted. The cystic mass along with the left tube was removed intact. The cyst was opened and noted to contain internal papillary excrescences. Frozen section diagnosis showed mucinous and serous components suggestive of low malignant potential.

A similar cystic mass within the mesosalpinx on the right was also removed intact with preservation of the right tube. This mass measured 6 cm. x 3.5 cm. x 1.5 cm. Upon opening the mass, no papillary projections were noted. Examination of frozen sections showed benign tissue. Pelvic washings were obtained. The abdomen was closed after careful inspection of the omentum and palpation of paraaortic and pelvic nodes. No other significant findings were noted and postoperative course was uncomplicated.

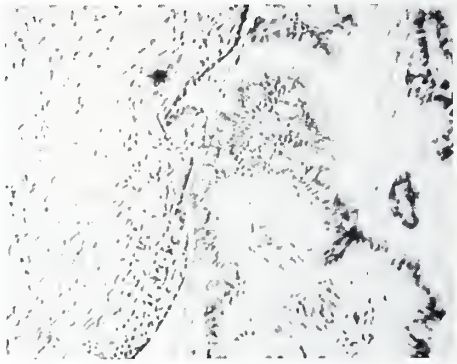

Figure 1. Adenocarcinoma of low malignant potential with both serous and mucinous components.

The patient resumed spontaneous menses and experienced her last period on March 6, 1989. She subsequently had an umcomplicated pregnancy, with spontaneous delivery of an 8-pound, 11½ ounce male on December 15. She remains clinically free of disease and is using oral contraception.

Pathology

The disproportionate left fallopian tube was histologically normal but stretched over a 7 cm. x 6.5 cm. x 5 cm. cystic parovarian mass. Multiple serial sections of the mass showed an adenocarcinoma of low malignant potential with both serous and mucinous components (Figure 1).

The cells were arranged in papillary projections lined by cuboidal cells, while other areas showed columnar cells with mucinous secretions. Papulations with papillary tufts showing mild hyperchromasia were noted. The lining of some papillae showed a single layer of cuboidal cells with mucin producing cells. The stroma consisted of fibrous tissue.

In focal areas, there were psammoma bodies and no mitoses were seen.

The wall of the stroma showed no invasion.

In other areas, the submucosa showed foamy histiocytes. A special stain for mucin showed occasional cells in the lining epithelium that were positive. The lumen also contained mucin positive material.

The right paratubal cyst measured 6 cm. x 3.5 cm. x 1.5 cm. and showed no papillary projections. The cyst was lined by a single layer of cuboidal cells with no evidence of malignancy. Pelvic washings contained occasional mesothelial cells with no evidence of malignancy.

Discussion

Parovarian cysts generally arise in the mesosalpinx, between the ovarian hilum and the fallopian tube. They may be of mesothelial, paramesonephric, or mesonephric origin (4).

Paraovarian cysts are considerably less frequent than ovarian cysts and malignant parovarian cysts are exceedingly rare (2). In a review of 140 parovarian lesions from Johns Hopkins, only four malignancies were noted, three of which were serous cystadenocarcinomas of low malignant potential (4).

The first parovarian malignancy was described by Lennox in 1952 (5). Since that time, 20 parovarian malignancies have been reported (2,3). Only eight of these were lesions of low malignant potential and were predominantly serous (2,3). Parovarian tumors of low malignant potential containing both mucinous and serous components are even more rare with only two previous case reports (2). This represents the third case reported and the only one with a reported subsequent successful pregnancy.

The histological appearance of tumors of low malignant potential is between a clearly benign and a frankly malignant lesion. Criteria for these lesions include stratification of the epithelial lining of the papillae, formation of tufts arising from the papillae, nuclear and cellular atypia, epithelial pleomorphism, and mitotic activity in the absence of stromal invasion (2). Since these lesions are so rare, little is known about their biologic behavior. It has been suggested, however, that they be managed similarly to low malignant potential lesions of ovarian origin (2).

As many as 40 percent of patients who have ovarian carcinoma of low malignant potential may have disease more extensive than Stage I A (6,7,8). The 15-year survival rate for women with ovarian tumors of low malignant potential has been reported to be 73 percent (2). It is essential that these women have complete staging laparotomies for treatment planning and it can be assumed that the same should be considered for parovarian cysts containing malignancy.

In those women who have completed childbearing, an abdominal hysterectomy with bilateral salpingo-oophorectomy along with staging laparotomy has been recommended. However, many of these lesions are found in younger women, the youngest patient reported being age 13 (4). In these types of cases, patients who meet certain clinical and histologic criteria may consider the option of preservation of reproductive capability.

Similarly, conservative management may be considered in parovarian cystadenocarcinomas of low malignant potential, if there are not external excrescences or adhesions, and if the lesion can be shelled out without rupture (2). The patient would require a thorough staging laparotomy with multiple biopsies to confirm localized disease. If there is evidence of disseminated disease, more aggressive surgery may be considered.

Appropriate therapy for this unusual lesion is yet to be fully defined, since so few cases have been reported. Most patients appear to have been treated with abdominal hysterectomy and bilateral salpingo-oophorectomy (2). However, for a small subset of patients which meet criteria for localized disease, conservative surgery with reproductive preservation may be appropriate.

The expected prognosis for our patient is good. She will require appropriate follow-up, since in cases of low malignant potential ovarian carcinomas, these lesions may have a tendency for late recurrence.

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Teen Outreach: A Grassroots Experiment in Social Psychiatry

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Abstract

In response to concerns about the social and psychological needs of teenagers, a Teen Outreach Program was established in Beckley, West Virginia. This program has received great support from the local community and can be conceived of as a grassroots experiment in social psychiatry.

In the program's first year, trained teenage volunteers under adult supervision, handled over 400 calls from teenagers on such topics as relationship problems, suicidal thoughts, drug and alcohol abuse, and sexuality. Teen Outreach is perceived by the entire community as beneficial and has expanded to encompass 33 counties.

Introduction

In February 1989, the National Association of the State Boards of Education invited the American Medical Association to join with it in calling national attention to dangerous trends in adolescent health and the need for action. In August 1989, a National Health Commission was formed and its findings were published as a Code Blue Report (1).

Some of the Code Blue findings were truly startling:

* Each year 10 percent of adolescent girls get pregnant;
* Of the high school seniors surveyed, 39 percent reported being drunk within the previous two weeks of the survey;
* The suicide rate for teenagers had doubled since 1968;
* Ten percent of adolescent boys and 18 percent of adolescent girls have attempted suicide;
* Every year more than two million children and adolescents are reportedly abused or neglected.

Recommendations of the Code Blue Report included:

(1) A guarantee that all adolescents have access to health services regardless of ability to pay;
(2) The enlistment of community organizations as front line participants in the battle for adolescent health;
(3) The organization of health services around people, not people around services; and
(4) A stronger role for schools in improving adolescent health.

In West Virginia, a study by the Governor's Task Force on School Health reported that 85 percent of high school students have tried alcohol; 20 percent have planned suicide; and 12 percent have attempted suicide (2). Alarmed by these findings, a group of concerned parents in Beckley were organized under the leadership of Dr. Ahmed D. Faheem to develop and implement a plan of action.

The Project

Beckley is a city with a population of about 33,000 in a semirural area. Most of the residents are coal miners who are currently in a state of economic depression. Dr. Faheem and several medical professionals in the city were well aware of the hardships and problems faced by the area teenagers since they had all worked with them in one capacity or another. Above all, they had teenage children of their own and out of their concern for them came up with the idea of the Teen Outreach Program.

To begin organizing the program, Dr. Faheem and the other physicians became involved with the local Student-Parent-Teacher Organization and presented seminars on teenage suicide, depression, pregnancy, and other issues dealing with teen-related problems. These seminars attracted much attention from the community and media, and attendance grew from a few dozen to several hundred people. Audience participation was very active and the organizers became increasingly aware that teenagers needed some way of expressing their feelings because they were not seeking professional help or using the existing mental health services.

A Board of Directors was formed which included a member of the Board of Education, the editor of the local newspaper, the owner of the local radio station popular with teenagers, an attorney, and representatives from the business community and civic organizations. The plans for the Teen Outreach Program were advertised to the community at large. It was explained that local teenagers would be trained to identify typical problems and prepared to help other teenagers in turmoil. Adult volunteers were recruited to supervise the teenage helpers. The program would utilize only telephone contacts and a telephone hotline was put into operation three hours a day from 6 p.m. to 9 p.m.

The program was created to be a service where calling teenagers could remain anonymous and feel free to talk about whatever was on their mind. All the calls would be answered by teenagers only, although adult supervisors would be available onsite to assist in crisis situations, especially medical emergencies.

Financial support was gathered from individuals and civic organizations, including the local Civitan Club and the Beckley Area Foundation. The organizers then went into the school system and lined up the support of the student government groups at various schools who would be able to publicize the program.

The response of the entire Beckley community was very positive, and after completion of a three-day training seminar for the

teenage helpers and adult supervisors, the program was inaugurated on May 10, 1989, by West Virginia's first lady.

During the first year of operation, 427 calls were received. Social problems, including family issues, incest, and abuse compromised 35.3 percent of the calls; 26.5 percent of the calls dealt with boyfriend/girlfriend problems such as unfaithfulness, steady relationship problems, pregnancy, and date rape; 12.5 percent focused upon problems with friends and lack of friends; and 12.5 percent dealt with alcohol abuse. Other topics included physical concerns (3 percent), sexual curiosity, (2.6 percent), and concerns about AIDS (0.23 percent). Twenty percent of the callers had suicidal thoughts, about a third of this group articulated suicide plans and had means available to commit suicide. In addition, 14 percent admitted to prior suicide attempts.

Discussion

The medical professions associated with the Teen Outreach Program have come to regard it as a grassroots experiment in social psychiatry. Community response has been overwhelmingly favorable and supporters of the program have developed justifiable pride in identifying a problem and then doing something about it. The program has dispelled the myth that media publicity about teen suicide has a negative impact upon teenagers because the media has helped with recruitment of teenage helpers, portrayed appropriately the negative aspects of suicide, and advertised the services available through Teen Outreach. The local radio stations even recruited the well-known rock musician, Jon Bon Jovi, to record commercials for Teen Outreach.

An attitudinal survey of teen volunteers who worked with the program showed that Teen Outreach helped them to better understand their peers' problems and communicate more effectively with their friends. While 28 percent of the teen volunteers had considered suicide sometime in their life, and 7 percent had attempted suicide before working on Teen Outreach, they all felt they were less likely to consider suicide after working in the program.

Among adult volunteers working with the program, 96 percent felt that Teen Outreach helped them understand the problems faced by teenagers better, and 92 percent felt that they could talk with teenagers better. While 23 percent had considered suicide before, 77 percent felt they were less likely to consider suicide after working with the Teen Outreach Program.

A random survey of 200 teenagers in the area indicated that 96 percent thought that it was a helpful project and that it was benefiting the teenagers in the community. In addition, 86 percent said that they would recommend Teen Outreach to a friend who may be having problems, especially since callers could preserve their anonymity and since confidentiality was such a high priority of the program.

Conclusion

The Teen Outreach Program was initially started by physicians and their spouses, who as members of the Raleigh County Medical Auxillary were both active in the program and helped raise funds. This program has energized the whole community into doing something positive for local teenagers. The program has been visited by Senator Jay Rockefeller, Governor Gaston Caperton, Congressman Nick Jo Rahall, and every member of the Legislature from Raleigh County. The program, originally started to serve one county in May 1989, has expanded to 33 counties and may even grow to include the rest of the state.

Although it is difficult to state with certainty that the program has prevented suicides or has decreased the morbidity associated with adjustment reactions, it is certain that many teenagers have utilized the program's services, and that the teenagers and adults working in the program have the perception that the service is beneficial.

Acknowledgement

Special thanks to Armando Favazza, M.D., of the Department of Psychiatry at the University of Missouri, for his help in preparation of this manuscript.

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Carcinoma of the Male Breast: A 27-Year Community Experience

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Abstract

Carcinoma of the male breast is relatively rare and the prognosis is usually more ominous than in the female. Radical mastectomy is advocated for optimal therapy but lesser procedures are used for a variety of reasons. After observing several recent cases of male breast cancer, we reviewed the tumor registries for the past 27 years at Marshall University affiliated hospitals. Thirteen cases were found and evaluated. This article presents treatment, survival and a review of the current therapy.

Introduction

Breast cancer in males is an uncommon disease, occurring less than 1 percent as often as in females. Each year in the U.S., an estimated 900 new cases of male breast cancer are diagnosed and 1,300 men die of the disease. Breast cancer represents less than 1 percent of all male malignancies (1).

The median age (65 years) for diagnosis of male breast cancer is several years later than female breast cancer (2). Analysis of the therapy of male breast cancer is difficult because of the small number of patients in most series. Due to the older age of most patients, mortality is often related to other causes and most reports show only a 5-year survival rate. Critchlow reported that male breast cancer patients had an average five-year survival rate of 49 percent, ranging from 79 percent in the node negative group to 28 percent in the node positive group (3).

Methods and Results

We reviewed all male breast cancers from 1960-1987 in three Marshall University affiliated hospitals. Thirteen cases (Table 1) were found ranging from 25-80 years (mean 56 years). Infiltrating ductal carcinoma was found in 12 and adenoid-cystic carcinoma in one. Surgical treatment consisted of radical mastectomy in seven patients, modified radical mastectomy in two patients, simple mastectomy in one patient, and only biopsy in three patients. Seven of the 13 (55.5 percent) had regional or distant metastasis at the time of operation.

TABLE 1

Patient	Age	Procedure	Metastasis	Outcome
1.	80	modified radical	none	alive 1 year later
2.	60	modified radical	none	alive 10 years later
3.	46	radical	none	alive 5 years later
4.	51	radical	none	alive 20 years later
5.	61	radical	regional	alive 2 years later
6.	58	radical	regional	died 1 year after
7.	58	radical	regional	died 1 year after
8.	40	radical	regional	died 1 year after
9.	69	radical	distant	died 1 year after
10.	25	simple	none	alive 7 years later
11.	30	excisional bx	none	alive 10 years later
12.	59	excisional bx	distant	died 5 years after
13.	74	excisional bx	distant	died 1 year after

The patients were divided into two groups for analysis. Nine patients underwent radical or modified radical mastectomy and five had regional or distant metastasis at surgery. The five-year survival rate for patients without metastasis was 100 percent vs. 20 percent for those with metastasis. The four patients who did not undergo a major surgical procedure (three biopsies, one simple mastectomy) did not undergo nodal evaluation for metastatic disease, but two patients had evidence of distant metastasis at the time of operation. The five-year survival rate for these patients was 50 percent. One of these patients had the diagnosis of adenoid-cystic carcinoma which usually carries a 100 percent, 5-year survival rate.

Discussion

The small numbers in this review do not allow a good statistical analysis of this disease process, but there does not seem to be a fairly good correlation with previously published articles. Critchlow's results reported in 1972 are very similar to those in our review (3). Kinne states that the standard approach in most series is the radical mastectomy (4). This is due to the proximity of male breast cancers to the pectoralis major muscle and to the more advanced stages of the disease in which most patients present. Some institutions prefer the modified mastectomy, due to the belief that excision of a portion of the pectoralis major muscle provides comparable results. Review of most series seem to support the findings of our small study. Analysis of our data along with that of the current literature supports the conclusion that radical or modified radical mastectomy results in prolonged survival, especially in the subgroup of patients without regional or distant metastasis.

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Use double spacing throughout, including (in the following order) title page, abstract, text, acknowledgements, references, tables, and legends for illustrations. Begin each of the following sections on separate pages: title page, abstract, text, acknowledgements, references, individual tables, and legends for illustrations. Number pages consecutively, beginning with the title page. Type the page number in the upper right-hand corner of each page.

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Where reference is made to generically-designated drugs, the first such reference must be followed by parentheses containing the most commonly known trade-name drug of that designation. In addition, a listing of all generic drugs mentioned in the article, with their trade-name equivalents, should appear at the end of the article.

Tables (tabular listings) and figures (photos, drawings and charts) should be numbered and the point of reference in the text indicated in parentheses, i.e., (Table 1), (Figure 1).

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Use the style of references seen in this *Journal*, which is based on the formats used by the U. S. National Library of Medicine in *Index Medicus*. The titles of journals should be abbreviated according to the style used in *Index Medicus*. Consult "List of the Journals Indexed," printed annually in the January issue of *Index Medicus*.

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President's Page

Constantino G. Amorsin M.D.

Health Care Access

Have you ever been at home alone when you were so ill that you did not even feel like getting out of bed to go to the medicine cabinet?

Access to health care services has become one of the major topics of discussion in our country. There are a myriad of "experts" expounding solutions to this issue, but in order to find an appropriate answer, it is necessary to understand the current situation.

There are an estimated 33 million people in the U.S. who have no health insurance. It is further estimated that 24 million or 73 percent of these uninsured individuals are workers and their families. Six million of these people are unemployed individuals with families who are below the federally established poverty level, but are not covered by Medicaid. Another estimated three million of these uninsured individuals are those considered "medically uninsurable" because of health conditions.

In West Virginia, approximately 300,000-350,000 people have no health insurance. For the purpose of this discussion, it is assumed that the breakout of these individuals is similar to the national analysis. Some feel that these people are totally disenfranchised from the health system. We, as physicians, know that is not true. However, we also realize that the services provided to some of these individuals can be improved.

In addition to the great number of uninsured citizens, there are many other factors that impact on the issue of access to health care in West Virginia. One problem is the fact that the lifestyle of West Virginians is recognized as the worst in our country. This creates a demand for services that exceeds those in other states.

Secondly, there are 155 physicians per 100,000 population in our state, compared to a national average of 223 physicians per 100,000 population. This means that we are trying to do more with 30 percent fewer physicians.

What has been and can be done to improve this situation?

To explore this question, let's look at what is currently being done to improve access:

1. The WVSMA is very active and was instrumental in creating the Healthy West Virginia Coalition. The charge of this group is to bring programs of prevention, wellness and health education to every West Virginian. Physicians are playing a vital role in this effort at the state and local level.
2. The physicians of West Virginia provide free services on a continuing basis. A 1990 survey showed that 26 percent of services by physicians in our state are provided without compensation.
3. Physicians are supporting and creating free clinics throughout the state and staffing them on evenings and weekends.
4. Physicians recently helped enact the Physician Provider Medicaid Enhancement Program which is designed as a means to improve eligibility for Medicaid services, thereby reducing the number of uninsureds.
5. By working with key state and national governmental officials, the WVSMA is improving the environment in West Virginia to make it a more appealing place to practice medicine.

In addition, the following can be done to further improve access:

1. The WVSMA endorses the AMA's Health Access America plan which includes:
   a. Requiring employers to provide health insurance for all full-time employees and their families in return for reduced taxes.
   b. Creating a state-level risk pool to make coverage available for people who are uninsurable due to pre-existing conditions.
   c. Reducing health care costs through professional liability reform (tort reform).
2. Expanding the current team approach used by physicians and mid-level providers to increase access to primary, preventive and educational health services.
3. Having practicing physicians participate in finding solutions to the problems of access that exist in their communities. The most effective resolution of this issue will be found at the grass-roots level.

I believe that the physicians in West Virginia stand ready to work for appropriate access to health services with all parties who are addressing this issue. By all of us working together to achieve this common goal, the people of West Virginia will surely benefit.

Governor Caperton is on the right track with his wellness prevention program because that is where our citizens greatly need educational assistance. The shortage of physicians in the state means that physicians assistants, nurse practitioners and nurse midwives have a definite role to fill, but diagnosis and treatment are simply not a part of it.

To allow these individuals to diagnose and treat simply for access is like having a two-tiered health care system in our state. I don't believe that this is the governor's intent. They can however, play a vital role in his wellness and prevention program.

As intended in the division of professional privileges, paramedical personnel are excellent choices for extension of physicians' capabilities to deliver medical care, as long as there is a direct responsibility established for a physician to take care of any complications that may emanate from that system. In light of the present malpractice climate, this can not be accomplished. The governor must take the lead to protect these physicians who would be willing to take that important responsibility.

Today, in spite of all its faults, in spite of what its critics say, American medicine is still looked upon as the best in the world. It was well said by a German medical student who visited me this summer when he commented, "In Germany, it is nice that I can go to a clinic or to a doctor for my colds, my appendix, my tonsils, but if I really get sick, I would like to be here in America."

Granted, there is a segment of our population who have no access to that certain care, but the most logical solution is to redefine and reassess our health care delivery system -- not to dismantle it.

—Constantino Y. Amores, M.D.

"I have never gotten used to people dying. And I don't want to get used to it."

Dr. Aliza Lifshitz, Internist, Los Angeles, California, Member, American Medical Association

Patients come to physicians for many reasons. Beyond relief from pain, they seek compassion, empathy and support. AIDS patients receive all of these and more from Dr. Aliza Lifshitz.

Born and raised in Mexico and educated at one of Mexico City's finest medical schools, Dr. Lifshitz now serves the Hispanic community in Southern California. Over a third of her patients have tested HIV positive. Most live below the poverty level. Many are illegal aliens.

"I never forget what it means to be a doctor, and what it means is embodied in the Principles of Medical Ethics of the American Medical Association (AMA)," states Dr. Lifshitz.

You are invited to join Dr. Lifshitz and to join with her in her efforts to bring quality health care to those in need. Become a member of the AMA today.

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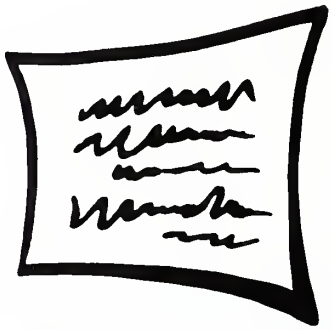

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At Mid-Winter

Panel to Explore Pros/Cons of TPA, Streptokinase

The use of Thrombolitic TPA vs. Streptokinase will be one of the subjects featured for the popular "Controversies in Medicine" panel discussion which will again be held during the Mid-Winter Clinical Conference, January 24-26, at the Radisson Hotel in Huntington.

This panel discussion is part of the Second Scientific Session and will be entitled "Why Not Use the Cheaper Spread(?)" Speakers will be Harold Selinger, M.D., F.A.C.C., medical director of the Heart Institute of West Virginia at the Charleston Area Medical Center, and Robert C. Touchon, M.D., F.A.C.C., F.C.C.P., professor of medicine at Marshall University. Dr. Selinger will focus on the use of Thrombolitic TPA and Dr. Touchon will present the opposing view with a look at Streptokinase.

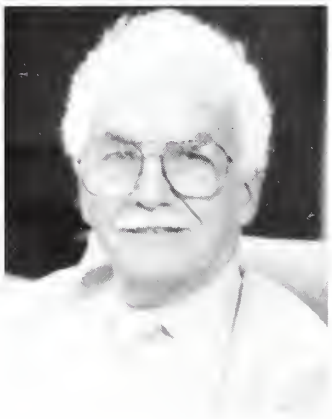
The first segment of Controversies in Medicine will explore Cesarean sections vs. vaginal births and will feature Robert P. Pulliam, M.D., an OB/GYN in Beckley who is the president-elect of the WVSMA, and Howard R. Gordon, M.D., professor and chairman of the Department of OB/GYN at West Virginia University. These speakers were profiled in the September issue of the *Journal*.

A registration form for the Mid-Winter Clinical Conference is printed on page and more details about the meeting are available by contacting Nancie Divvens at 925-0342.

Speakers Highlighted

Dr. Selinger was born in New York City and received his premedicine degree from Brooklyn College and his medical degree from the State University of New York in 1953. He did his internship at Maimonides Hospital in Brooklyn and then started his residency at the Jewish Hospital of Brooklyn, but left to serve as a general medical officer in the U.S. Air Force for two years.

Dr. Touchon



Dr. Selinger

Following his military service, Dr. Selinger resumed his residency in 1956 at the Jewish Hospital of Brooklyn, where he also later served as a fellow in the Cardiology and Cardiopulmonary Laboratory and as an assistant in medicine and cardiology. In addition, from 1960-1962, he was a clinical instructor at the State University of New York at Downstate Medical Center.

In 1962, Dr. Selinger relocated to Charleston to establish and direct the Cardiac Catherization Laboratory at the former Charleston Memorial Hospital, which is now the Memorial Division of Charleston Area Medical Center. Dr. Selinger was in charge of the Cardiac Catherization Laboratory until the end of 1985 when he was named director of the Heart Institute of West Virginia at CAMC.

During his career, Dr. Selinger has served in many capacities at CAMC including chairman of the Department of Medicine, chief of staff, and as a member of the executive committee and board of trustees. Active in many state and national health associations, Dr. Selinger was a consultant in cardiology for the West Virginia State Division of Crippled Children from 1963-1985 and was governor of the American Academy of Medical Administrators from 1987-1989.

A clinical professor for both the West Virginia University and Marshall University Schools of Medicine, Dr. Selinger was a contributing editor for the book "Computer Electrocardiography, Present Status and Criteria," and has written many scientific articles.

Dr. Touchon received his undergraduate degree from Occidental College in Los Angeles and his medical degree from Saint Louis University in St. Louis. He did internal medicine residencies at Santa Barbara General/Cottage Hospitals in Santa Barbara and at the University of Pennsylvania.

Following his residencies, Dr. Touchon was a clinical cardiology fellow at Saint Vincent Hospital at the University of Southern California from 1968-1969 and then completed a fellowship in cardiology research at the University of California at Los Angeles. He joined the United States Air Force in 1970 and served as a medical corp flight surgeon and as director of the catherization laboratory and chief of cardiopulmonary research function at Brooks Air Force Base in Texas for two years. During this time, Dr. Touchon also taught physiology and

Dr. Amores Honored

WVSMA President Constantino Y. Amores, M.D., beams with pride after Governor Gaston Caperton named him a "Distinguished West Virginian" and presented him with a framed certificate at a ceremony in the governor's office on October 24. Governor Caperton presented the award to Dr. Amores in appreciation for his 20 years of dedicated service to the medical profession as well as his leadership with the WVSMA.

medicine at the University of Texas Medical School in San Antonio.

After completing his military duty, Dr. Touchon returned to California in 1972 to accept a position as medical director of the Cardiac Diagnostic Institute in Fullerton. Two years later, he was named director of cardiac rehabilitation at the institute, and in addition became director of coronary care at Anaheim Memorial Hospital in Anaheim. From 1975-1977, Dr. Touchon held a variety of management roles at the two facilities and was a clinical instructor of medicine at the University of California at Irvine.

Dr. Touchon moved to Colorado in 1978 to become director of intensive care at Mercy Medical Center in Durango, where he also later served as chief of medicine and chief of staff-elect. Three years later, he relocated to Huntington to join the staff of Veterans Administration Medical Center as chief of cardiology and become an associate professor and chief of cardiovascular medicine at the Marshall University School of Medicine, a post he still holds today.

In 1985, Dr. Touchon was promoted to professor of medicine and physiology at Marshall and since that time he has also assumed responsibilities as director of cardiac rehabilitation at Cabell Huntington Hospital and chief of cardiology at St. Mary's Hospital.

WVACP Plans First Scientific Meeting

For the first time, the West Virginia Chapter of the American College of Physicians is holding its scientific meeting independent of the Eastern and Western Pennsylvania Regions, and has scheduled this special session for January 23-24 at the Huntington Radisson Hotel, prior to the beginning of the WVSMA's Mid-Winter Clinical Conference.

"I am very pleased to announce our first annual meeting and I feel we have a very strong program for participants," Dr. Robert Marshall, governor of the WVACP Chapter and a clinical professor of medicine at the Marshall University and West Virginia University Schools of Medicine said. "I am hopeful that having our meeting in conjunction with the WVSMA's Mid-Winter Clinical Conference will encourage attendance at both events," he added.

The conference will open on Thursday evening, January 23 at 6 p.m. with a reception. At 6:50 p.m., Dr. Marshall and Dr. Maurice Mufson, professor and chairman of the Department of Medicine at Marshall University, will deliver welcome addresses and then associates, residents and fellows in internal medicine and its specialties will give papers on a wide variety of topics.

On Friday, the conference will start with breakfast at 7:30 a.m. Dr. Marshall will give additional opening remarks at 8:15 a.m. and then the first speaker, Charles E. Turner, M.D., F.A.C.P., clinical professor of medicine at Marshall, will lecture on "Chronic Viral Hepatitis: New Treatment." Immediately following, Rolf M. Gunnar, M.D., F.A.C.P., professor of medicine at Loyola

(Continued on next page)

CORRECTION

In the October issue of the *Journal*, Delegate Joe Martin's name and county appeared incorrectly in a photo caption in the Special Section on the WVSMA's Annual Meeting. This caption should have read Delegate Joe Martin (D-Randolph) instead of Senator Joe Martin III (D-Marion).

We apologize for this error.

ACP Meeting

(Continued from previous page)

University Medical Center in Maywood, Ill., and the official college representative for ACP, will discuss "Update in Cardiology." The third topic, "Erythropoietin in Chronic Anemia" will be addressed by Derrick L. Latos, M.D., of Wheeling, who is a clinical professor of medicine for WVU.

Following a break at 10 a.m., the meeting will reconvene with Anthony DiBartolomeo, M.D., F.A.C.P., professor of medicine and chief of the division of rheumatology at WVU, speaking on the subject "Osteo: Is It Osis or Itis?" Next, Dr. Gunnar will give a report from ACP headquarters in Chicago and Elizabeth Chalmers, from the Washington, D.C. office of ACP, will provide participants with an update on legislative issues.

The scientific meeting will conclude at 12:15 p.m. after a presentation by Bruce S. Chertow, M.D., F.A.C.P., professor of medicine at Marshall University who recently completed a six-month sabbatical at the Baker Institute in Melbourne, Australia. Dr. Chertow will discuss "New Causes of Old Diseases."

Physicians who are not members or fellows of ACP are welcome to attend the conference. Advance registration information is available by contacting Dr. Marshall's office at 528-4676. On-site registration will also be offered.

WVU Names Winners of Resident Trauma Papers Competition

Rebecca Price, M.D., a third-year general surgery resident, and Daniel Sadler, M.D., a resident at the Charleston Area Medical Center, tied for first place in the Second Annual Resident Trauma Papers Competition of the state chapter of the American College of Surgeons.

Other WVU residents to win honors included Ronald Bauer, M.D., fifth-year surgery resident, who was awarded second place; Deborah Blumenthal, M.D., neurosurgery resident, who placed third; and Mark Nelson, fifth-year surgical resident, who received an honorable mention.

Book Review

HEALTH CARE FRAUD AND ABUSE
A Guide to Federal Sanction

Clark Boardman Company
A Division of Thompson Legal Publishing, Inc.
Paul P. Cacioppo, Editor
$95

Clark Boardman, the publisher, deals strictly in legal matters. *Health Care Fraud and Abuse* is written and compiled -- "to provide lawyers and lay persons basic information about health care practices of which Congress disapproves."

The Medicaid Enhancement Fund created by the Legislature and endorsed by the West Virginia State Medical Association House of Delegates could conceivably direct some serious attention to matters dealt with in this book. It seems possible that certain special taxes imposed by states in order to extract more matching money from the federal government for medical purposes could fall under the general category of "health care practices of which Congress disapproves." Rather than taking a platoon of lawyers to make such a determination, this book, in proper hands, might reduce the number of lawyers required to a squad or two.

The first lines in the introduction are eye opening -- "Any person or legal entity that provides goods or services for health care may be subject to sanctions under the Medicare and Medicaid statutes, or under a variety of other federal statutes, if delivery or performance of those goods or services involves fraud or abuse." The introduction goes on to point out, not too delicately, "that means those who want federal or federal/state money for their health care goods or services must play by federal and state rules."

The book is neatly arranged and, at intervals, is almost interpretable by a physician. Lawyers, no doubt, find reading text books of medicine equally as enigmatic and soporific.

Each section in this clearly indexed book gives general government guidelines involving fraud and abuse of the Medicare system. There are extensive cross references listed under each section to allow for much greater and in-depth research involving the topics covered.

Excerpts are taken from the Medicare Statutes, including the Omnibus Reconciliation Act of 1989. Both of these documents would need researched in more depth to clarify any issue.

Government guidelines are given on all issues. Some issues have individual state guidelines.

Doctors with a keen interest in law, an interest in avoiding legal harassment, and well caught up on their sleep might want to spend an evening perusing the contents of this book. It is much more likely, however, that doctors will be happy to recommend and refer this book to their own personal lawyer or tax attorney. Government attorneys seem to have their own primer in ways to pick at and harass physicians. *Health Care Fraud and Abuse* could anticipate legal forays from government bassett hounds and thereby provide a legal bulwark against such harassment.

Need a Christmas present for your tax attorney? This book is a possibility.

Worried about billing practices in your business office? Here is a quick reference:

Christy Morris, Acting Billing Manager
The Wheeling Clinic
232-3600

—Stephen D. Ward, M.D.

The AMA
Hospital Medical Staff Section
Eighteenth Assembly Meeting
December 5 - 9, 1991
Las Vegas Hilton Hotel
Las Vegas, Nevada

Highlights of the Interim Meeting will include:

- an educational program on RBRVS: Physician Payment Reform or Retribution;
- presentation by the AMA-HMSS Governing Council of reports on medical staff issues including temporary Hospital Medical Staff Privileges, Joint Commission Revisions for the 1992 Accreditation Manual for Hospitals; and Advance Directives;
- an information exchange on PRO Scope of Work and Uniform Clinical Data Sets: What You Should Know.

For Information Contact:

Department of Hospital Medical Staff Services
American Medical Association
515 North State Street
Chicago, Illinois 60610
Phone (312) 464-4754 or 464-4761

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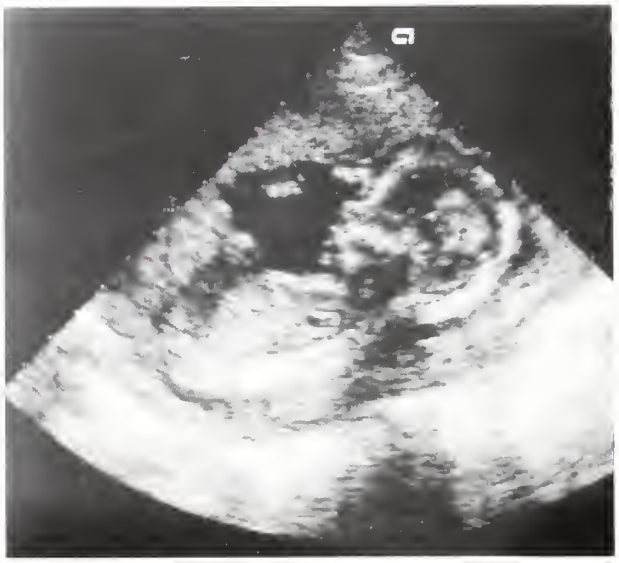

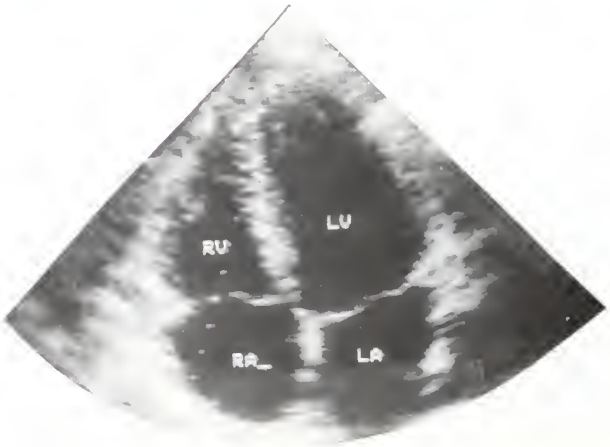

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Laser Surgery Seminar VIII

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Continuing Education

Listed on this page are some of the upcoming continuing education programs which will be held throughout the state.

The programs this month were compiled by the following individuals: Robin Rector, coordinator of CME for Charleston Area Medical Center; Cynthia Kemp, WVU conference planner; Marie Chute, secretary of the Ohio Valley Medical Center CME Department; and Thelma Wilson, education coordinator of the Raleigh County Medical Society.

These programs are tentative and subject to change. Further details about these CME activities may be obtained by calling Rector at 348-9580; Kemp at 293-3937; Chute at 234-8310; and Wilson at 255-6341. Other national and state meetings are listed in the Medical Meetings Section of the *Journal.*

This schedule is presented as a convenience for physicians. If you would like to have the continuing education programs offered by your institution or association published in the *Journal,* please contact Nancy Hill, managing editor, at 925-0342.

CAMC/WVU Health Sciences Center - Charleston

Nov. 21 - "Sports Medicine - Athletic Weight Loss Programs: Criteria for Wrestling Weight Loss," (Teleconference), Room 2000, WVU Health Sciences Center, and Room 420, CAMC General Division, 3 p.m. - 4 p.m.

Nov. 25 - "Evaluation and Management of Lipid Abnormalities," (Teleconference), Room 2014AB, WVU Health Sciences Center, 12:30 p.m. - 1:30 p.m.

Dec. 7 - "Update on Pediatric Endocrinology," WVU Auditorium, 8 a.m. - 3:30 p.m.

Dec. 9 - "Traumatic Brain Injury," (Teleconference), Room 2014AB, WVU Health Sciences Center, Room 420, CAMC General Division, 12:30 p.m. - 1:30 p.m.

WVU Health Sciences Center - Morgantown

Nov. 22-24 - "8th Annual Hypnosis Workshop"

Ohio Valley Medical Center - Wheeling

Nov. 20 - "Treatment of Diabetic Retinopathy," Judie Charlton, M.D., of the WVU School of Medicine, 8 a.m.

Nov. 27 - "New Data and Directions for Long-Term Patient Care," Robert G. Narins, M.D., of the University of Michigan Medical School and Henry Ford Hospital, 8 a.m.

Dec. 11 - "New Perspectives in Non-A and Non-B Hepatitis," David VanThiel, M.D., of the University of Pittsburgh, 8 a.m.

Raleigh County Medical Society-Beckley

Nov. 19 - "Insulin Resistance in Hypertension," Black Knight Country Club, 6:30 p.m.

Outreach Programs

Key to Sponsors

★ *WVU Health Sciences Center, Morgantown*

☐ *CAMC/WVU Health Sciences Center, Charleston*

Bluefield ☐ Bluefield Community Hospital, Dec. 4, 1 p.m. - 2 p.m., "Pediatric Update," STBA*

Madison ☐ Boone Memorial Hospital, Dec. 10, 6:30 p.m. - 7:30 p.m., "Hypertension Update," Julian Espiritu, M.D.

Man ☐ Man Appalachian Regional Hospital, Nov. 19, 7 p.m., "Traumatic Brain Injury," Evalyn Bishop, Ph.D., and Kathy Holliday, RN

Montgomery ☐ Montgomery General Hospital, Dec. 4, noon - 1 p.m., "Amputee Program," Kenneth Wright, M.D., Pat Williams, Medical Rehabilitation, and Donna Busch, RN

Ripley ☐ Jackson General Hospital, Dec. 13, noon - 1 p.m., "Spinal Cord Injury," Mario Balmeseda, M.D., and Kathy Holliday, RN

Spencer ☐ Roane General Hospital, Nov. 19, 12:30 p.m., STBA*

**STDA—Speaker to be announced*

Electromyography and Nerve Conduction Studies.

★

Prasadarao B. Mukkamala, MD
Diplomate of American Board of Physical Medicine and Rehabilitation.

Diplomate of The American Board of Electro-Diagnostic Medicine

★

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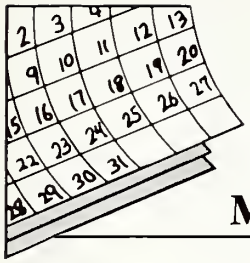
★

Prasadarao B. Mukkamala, MD
1200 Quarrier Street
Charleston, WV 25301



Medical Meetings

December

1-6—American Association of Women Radiologists, Boston.
1-6—77th Scientific Assembly of the Radiological Society of North America, Chicago.
5-8—American Association for Cancer Education, Baltimore, Md.
5-8—American Academy of Psychoanalysis, New York City.
6-8—American Academy of Psychiatrists in Alcoholism and Addictions, Naples, Fla.
7—Eighth Annual Clinical Update in Pulmonary Medicine, Deborah Heart and Lung Center, Atlantic City.
7-8—Nutrition for Clinical Practice and Everyday Living, Ohio State University, Columbus.
8-10—Special Ross Conference on Hot Topics '91 in Neonatology, Washington, D.C.
11-13—NIH Consensus Development Conference on Acoustic Neuroma, National Institute of Neurological Disorders and Stroke and NIH Office of Medical Applications of Research, Bethesda, Md.
14—The New Anti-Depressants, Ohio State University, Columbus.

January

15-18—Contact Lens Association of Ophthalmologists, Las Vegas.
16-18—American Academy of Pain Medicine, Scottsdale, Ariz.
18—Tardive Dyskinesia, Ohio State University, Columbus.
19-25—18th Southern Clinical Neurological Society Meeting, Islamorada, Fla.
24-26—West Virginia State Medical Association's Mid-Winter Clinical Conference, Huntington.
29-31—Southern Society for Pediatric Research, New Orleans.
31-February 2—1st Conference on Imaging in the Health Sciences, University of Texas, Houston.

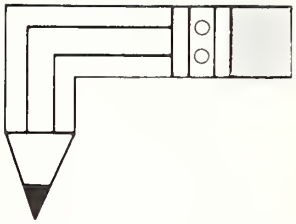
February

10-12—Aging: The Quality of Life, Christopher Columbus Medical Sciences Committee of the National Institute of Health, Washington, D.C.
10-12—Beyond Deficiency: New Views on the Function and Health Benefits of Vitamins, New York Academy of Sciences, Arlington, Va.

For More Information . . .

Contact the Journal for additional information about most of the above meetings. Call (304) 925-0342.

Poetry Corner



Night Sounds

The silence of the night
Falls o'er wooded hills
And drifts down valley floors,
Closing out the day,
When nightshade falls.

But listen carefully
And the silence of the night
Is filled with many sounds
And sounds, and sounds,
And other sounds.

The rippling mountain stream,
Where late today
I saw a large brook trout,
Sings pleasantly
While rushing on toward the sea.

Then from afar, against a hill,
The night-owl calls,
And rustling leaves
Softly sing their song
While stirring in a gentle breeze.

The snapping of some twigs
Says deer are close around,
And from afar, another owl
Answers to the first
With haunting call.

The scurry near of little feet
As forest creatures roam,
Keeping active even now,
And the silence of the night
Is filled with many sounds.

E. Leon Linger, M.D.

Please address your submissions for Poetry Corner to: Stephen D. Ward, M.D., Editor, West Virginia Medical Journal, Box 4106, Charleston, WV 25364.

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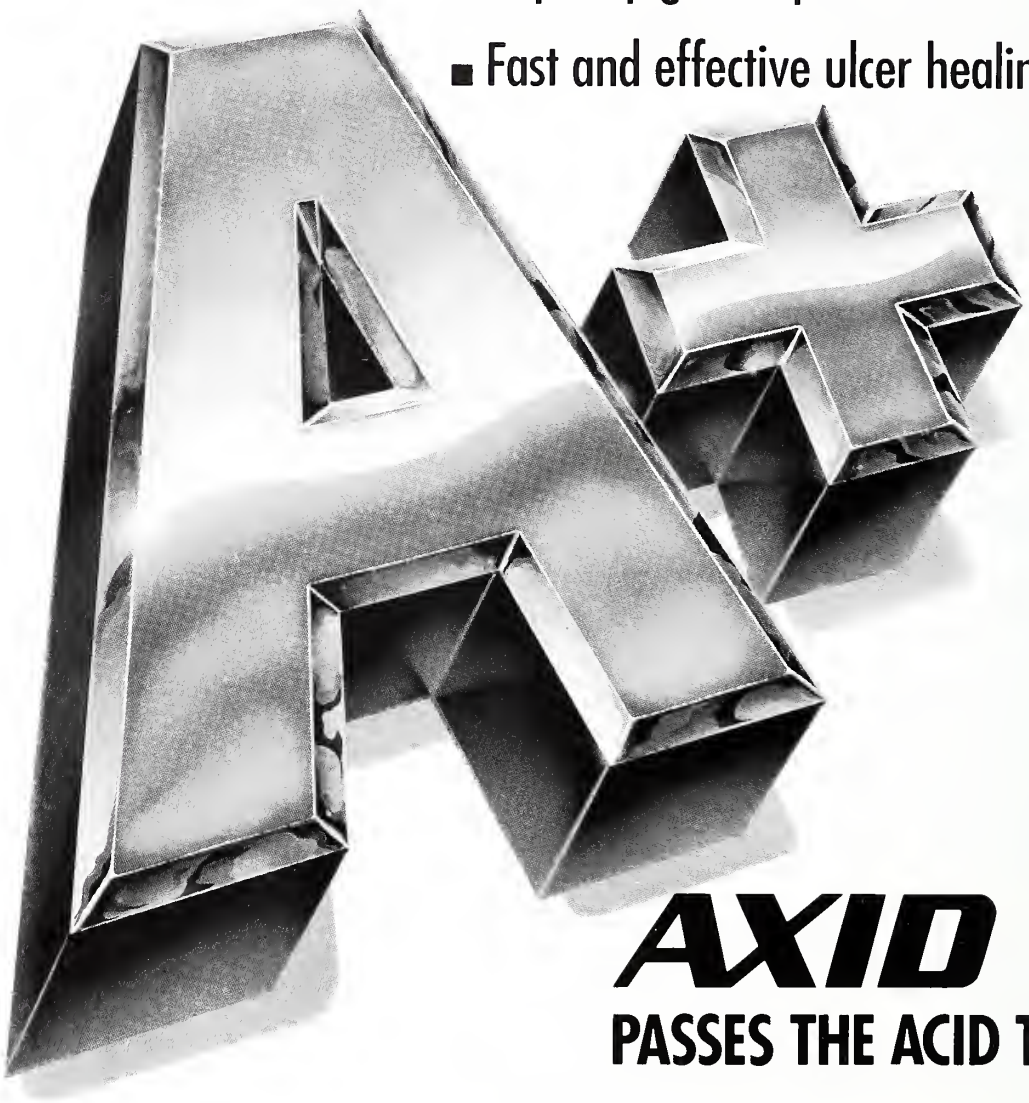

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See adjacent page for references and brief summary of prescribing information.

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Indications and Usage: 1. *Active duodenal ulcer*—for up to 8 weeks of treatment. Most patients heal within 4 weeks.

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Carcinogenesis, Mutagenesis, Impairment of Fertility—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,900 nizatidine patients and over 1,300 on placebo, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events were due to the drug.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H_2-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H_2-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis does not substantially increase clearance of nizatidine due to its large volume of distribution.

PV 2091 AMP
[091190]

References
1. Data on file, Lilly Research Laboratories.
2. *Scand J Gastroenterol* 1987,22(suppl 136):61-70.
3. *Scand J Gastroenterol* 1987,22(suppl 136):47-55.

NZ-2943-B-149347

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WEST VIRGINIA UNIVERSITY HEALTH SCIENCES CENTER

Compiled from material furnished by the West Virginia University Health Sciences Center News Service, Morgantown.

D'Alessandri to Lead Health Sciences Center

Dr. Robert D'Alessandri

Robert M. D'Alessandri, M.D., will become West Virginia University's vice president for health sciences on July 1 and will continue to serve as dean of the School of Medicine.

Dr. D'Alessandri has been dean of the School of Medicine since March 1989. As vice president, he will also have administrative responsibility for the WVU Schools of Dentistry, Pharmacy and Nursing, as well as a number of centers and institutes.

Dr. Robert Biddington, formerly dean of dentistry, is currently serving as vice president for health sciences and will continue in that role until Dr. D'Alessandri assumes the position next July.

"Bob D'Alessandri has demonstrated an exceptional capacity for creative and effective leadership, not only within the School of Medicine but statewide," said WVU President Neil Bucklew. "He has been a key player in the development of new approaches to the challenges of health care delivery and health professions' education in West Virginia. He assumes the vice presidency at a time when the Health Sciences Center itself is in a process of significant change. Much of that change was initiated by Dr. D'Alessandri."

Dr. Bucklew said consolidating the two positions will save WVU about $100,000 annually while requiring only minimal changes in the organizational structure of the Health Sciences Center.

Dr. D'Alessandri stated that his appointment represents a determination to be responsive to the needs of the people of West Virginia.

"When I became dean, I knew that we had a school of high quality, with many areas of real excellence," Dr. D'Alessandri said. "I saw my task as building on that excellence and looking for new opportunities to put our resources at the service of the state. I see the new joint position of dean and vice president as confirmation of an institutional commitment to change. I hope that my experience working with state leaders in government and health care will enable us to make the most effective match between the needs of West Virginia's people and the many resources an institution like the Health Sciences Center can offer."

Trauma Doctor Receives Medal

Gregory A. Timberlake, M.D., director of the Jon Michael Moore Trauma Center, has received the National Defense Service Medal. He was recalled as a naval reservist in conjunction with Operation Desert Shield/Storm and served as a staff surgeon on the USNS Comfort, which was deployed in the Persian Gulf during the war.

Dr. Timberlake also served as staff general surgeon at the National Naval Medical Center in Bethesda, Md., and as a staff surgeon at MED STAR, Washington Hospital Center in Washington, D.C.

Surgery Profs Speak in South America

Julio Hochberg, M.D., associate professor of surgery, and Donald E. McDowell, M.D., professor of surgery, both recently spoke at conferences in South America.

Dr. Hochberg visited his native country of Brazil to address the Latin-American Congress of Plastic Surgeons on "Chest-Abdominal Wall Reconstruction." In addition, Dr. Hochberg also presented Grand Rounds at the Medical College of Georgia, and gave a lecture at the Southern Surgical Congress in New Orleans during his recent travels.

Dr. McDowell discussed the evaluation of abdominal aortic aneurysms and deep venous insufficiencies of the lower extremities for the Paraguayan Surgical Society, which he helped to found. He also conducted two teaching rounds at the Baptist Hospital in Asuncion.

Drs. Sohrabi, Robison Given Special Honors

Dr. Robison

Abdolkarim Sohrabi, M.D., associate professor of surgery at WVU, and Joan T. Robison, Ph.D., associate professor in the Department of Behavioral Medicine and Psychiatry at the WVU Health Sciences Center in Charleston, have recently received national recognition.

Dr. Sohrabi was accepted into membership by both the Society for Surgical Oncology and the Society of American Gastrointestinal Endoscopy Surgeons. He is a fellow of the American College of Surgeons and a Board Certified surgeon.

Dr. Robison was elected to a three-year term on the Council of Representatives of the American Psychological Association. She will represent the Division of Health Psychology at the APA.

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MU School Of Medicine News

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Health Statistics Study Released

A Marshall University medical study comparing communities near industrial sites to towns farther from them showed few statistically significant differences.

The study sought to learn whether there were differences in death statistics, differences in the health events people recalled, and differences in how people perceived their health status, said Dr. Robert B. Walker, chairman of Marshall's Department of Family and Community Health.

The focus of the finished study is more narrow than originally planned, primarily because too few people were willing to participate. The towns studied were Ceredo, Guyandotte and Kenova (considered close to industrial sites) and Barboursville, Hamlin and Lesage.

The study, funded by a Gannett Foundation grant, found that residents of Kenova considered their health poorer than residents of Barboursville did, although residents of Ceredo and Guyandotte did not. Kenova residents also recalled having more headaches than residents of Barboursville, Hamlin and Guyandotte did.

There was no statistical difference in numbers of deaths or causes of death between any community and the six-community group. In comparing individual communities, however, Barboursville showed a somewhat higher rate than Hamlin in percentage of deaths from cancer and from those causes grouped as "possible environmental causes." Barboursville also showed a higher unadjusted rate of deaths from birth defects than Guyandotte did.

Dr. Walker urged caution in interpreting the findings, noting that death certificate information can be unreliable, that it is difficult to compare data that is not adjusted for age and gender, and that perceptions of health status and recollections of health events are subjective. The Marshall study made no attempt to link health differences to any possible causes, he added.

Representatives of industry, the West Virginia and Kentucky air pollution control boards, the West Virginia Division of Health, the West Virginia Legislature, the Cabell County Medical Society, the School of Medicine, and private individuals formed an advisory group which determined policy for the study.

The researchers compiled statistics from death certificates and conducted interviews of randomly selected households. Interviewers contacted 1,325 households in the six areas. Thirty-five percent declined to participate or withdrew consent, and 245 households could not be reached in three attempts. Most questions in the survey came from the National Health Survey and the Kanawha Valley Health Study. The data was analyzed by Ohio State University.

Five Rural Doctors Honored for Service

Drs. Michael Kilkenny, Daniel Doyle, Lisa Elliott, Carroll Christiansen and Sven Jonsson have received community service awards from the Marshall University School of Medicine for their pioneering role in the school's new Rural Physician Associate Program.

In this new program, the doctors were each assigned to one of the three medical centers - - Wayne Health Services, New River Family Health Center, or Roane County Family Health Center - - to receive virtually all of his or her third-year education.

"These physicians were wonderful," Dr. Linda Savory, associate dean for curriculum and evaluation said. "They took on a unique responsibility for a full nine months of student education. The burden was on them to provide quality education around the clock, seven days a week, and they accomplished that ambitious goal. They put their stamp of influence indelibly on the students they worked with."

The Rural Physician Associate Program was originated by the University of Minnesota, and has the best track record of any training program in the nation for producing rural physicians, Dr. Savory said. Marshall is only the third school to implement the program.

FP Graduate Working at Cabin Creek Clinic

The Cabin Creek Medical Center now has its first ongoing physician since its reopening -- Dr. J.D. Young, a graduate of Marshall's family practice residency program.

Dr. Young, who has a master's degree in public administration/ hospital administration in addition to his M.D. degree, will spend two days each week at the center. The state's medical schools will continue to provide additional faculty and resident physicians on a rotating basis.

"I've always been interested in something other than a regular suburban practice," Dr. Young said. "This will provide variety, and it seems to be a freer, more relaxed atmosphere."

Until Jan. 1, Dr. Young will continue to work three days a week in Marshall's Department of Family and Community Health and then he will be a full-time faculty member at West Virginia University.

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Wilhelm S. Albrink, M.D.

Dr. Wilhelm Stockman Albrink, 75, of Morgantown, died July 28 at Alta Bates Hospital in Berkeley, Calif. following a brief illness.

Dr. Albrink was born in Napoleon, Ohio. He graduated from Oberlin College in 1937 and received his Ph.D. and M.D. degrees from Yale University.

Following a residency in pathology at Yale - New Haven Hospital from 1947-50, Dr. Albrink joined the faculty and achieved the rank of associate professor. His academic career at Yale was briefly interrupted from 1954-56, while he served with the U.S. Army Medical Corps in medical research at Fort Dietrick, Md.

Dr. Albrink and his family came to Morgantown in 1961, when he was appointed professor and chairman of the Department of Pathology at the WVU Medical Center. He was one of the early core faculty when the four-year WVU School of Medicine opened in 1961. In 1969, he resigned from the departmental chairmanship, but continued to have an active role at the medical school, retiring as professor emeritus in 1981.

As professor emeritus, Dr. Albrink was instrumental in creating the bioethics program, and later served on the Institutional Review Board for Research on Human Subjects, which he chaired from 1985-90. He also established the History of Medicine Society, later renamed the Whittlesley Society, and for many years, served on the School of Medicine's Admissions Committee.

Dr. Albrink was a member of Alpha Omega Alpha, Sigma Xi, and the Association of American Pathologists. He authored numerous papers in the field of pathology and participated in many seminars on medical ethics.

Dr. Albrink was a recipient of this year's WVU Vandalia Award. The university recently held a memorial service in his honor and established the Wilhelm S. Albrink Lectureship in Bioethics, an endowment to support visiting lectures from other universities.

Survivors include his wife, Dr. Margaret Joralemon Albrink, who recently retired as professor emeritus of medicine at WVU; three sons, Dr. Frederick H. Albrink of Omaha, Neb., John W. Albrink of New York City, and Peter V. Albrink of Rochester, Minn.; two brothers, Frederick Albrink of Norfolk, Va., and Karl Albrink of La Bita, Colo.; and two grandchildren.

William C. Covey Jr., M.D.

William C. Covey Jr., M.D., 71, of Beckley, died October 11 at his residence, following a sudden illness.

Born in Sullivan, Dr. Covey graduated from Woodrow Wilson High School and received his pre-medical education at Duke University, and his M.D. degree from Temple University in 1944.

After a rotating internship at Philadelphia General Hospital, Dr. Covey served as a lieutenant junior grade in the Navy during World War II. After the war, he returned to Beckley and was a surgical resident at Beckley Hospital. He then completed a four-year residency in obstetrics and gynecology at the University of Maryland.

After 17 months in private practice, Dr. Covey served as a lieutenant in the Navy during the Korean War. Following this tour, he resumed private practice in Beckley and for over 25 years, he also served as a consultant to the Hygea Foundation Clinics at Oceana and Whitesville.

Dr. Covey was on the medical staffs at Raleigh General and Beckley Hospitals and had served as president of the Raleigh County Medical Society and as a WVSMA councilman. He was a member of Delta Tau Delta Fraternity, the Beckley Rotary Club, Black Knight Country Club, Elks Club, and the Beckley-Raleigh County Chamber of Commerce. Dr. Covey also had served as president of Rotary, where he had received the Rotarian of the Year and the Paul Harris awards.

Survivors include his wife, Anneva French Covey, M.D., of Beckley; two sons, William C. Covey III of Gainesville, Fla., and Douglass F. Covey of Jacksonville, Fla,; and a granddaughter, Megan Renee Covey of Jacksonville, Fla.

McDowell

Two new members, Drs. Romulo Dela Rosa and Siva Prasad Jagarlapudi were voted in at the September meeting.

Members reviewed letters from the WVSMA offering to schedule both a visit from President Constantino Y. Amores, M.D., and also a speaker from McDonough Caperton Insurance Group. Due to the small size of the group, it was decided not to set up either meeting. In addition, a thank-you note from the Delaware Special Olympics was received for the society's recent donation.

Monongalia

John Spiker, director of Morgantown Physical Therapy Associates, was the speaker for the October 1 meeting.

Dr. Antonelli extended his thanks to the physicians and other health care professionals who volunteered their time at the Morgantown Health Right Clinic during September.

Nora Wenig, a fourth-year medical student, made a request for a contribution to the Ronald McDonald House on behalf of a group of students from the WVU Health Sciences Center. Dr. Sebert recommended the society donate $200 and the issue will be discussed at the next business meeting.

Dr. Jakubec then discussed low attendance at the meetings.

Raleigh

At the society's September meeting, Dr. Ahmed Faheem was chosen to serve on the WVSMA Council.

In other business, Dr. William Scaring, secretary/treasurer, reported that September was "Women in Medicine" month and that a recent article in the local newspaper was the result of information provided by the society. Dr. Scaring also acknowledged the women members.

Featured speaker for the evening was member Dr. Eileen Catterson, president of the West Virginia Board of Medicine. Dr. Catterson brought the members up-to-date on new legislation and regulations pertaining to the Board of Medicine.

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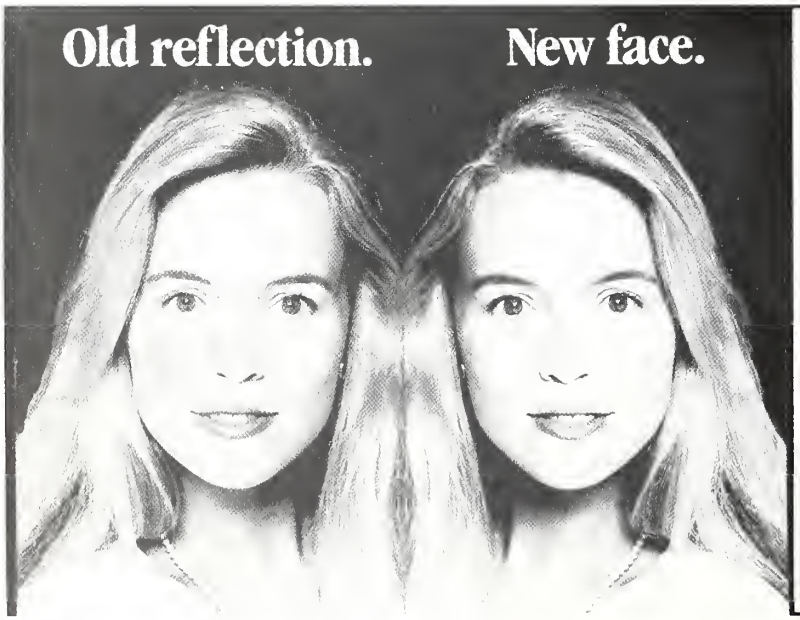

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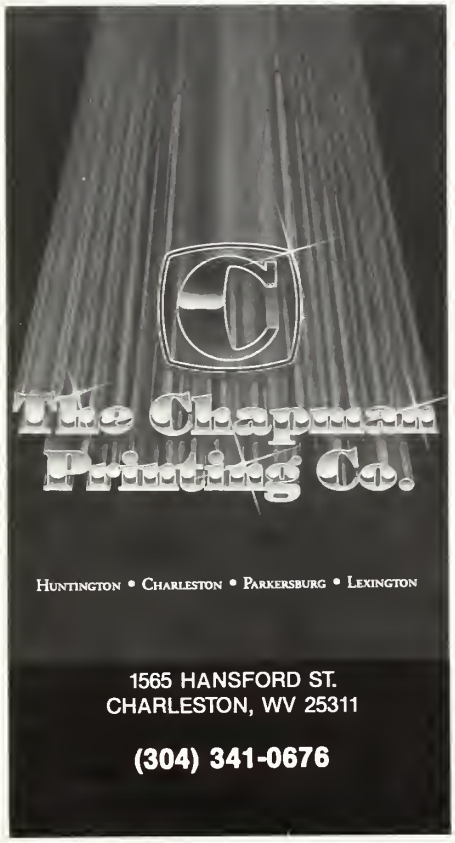

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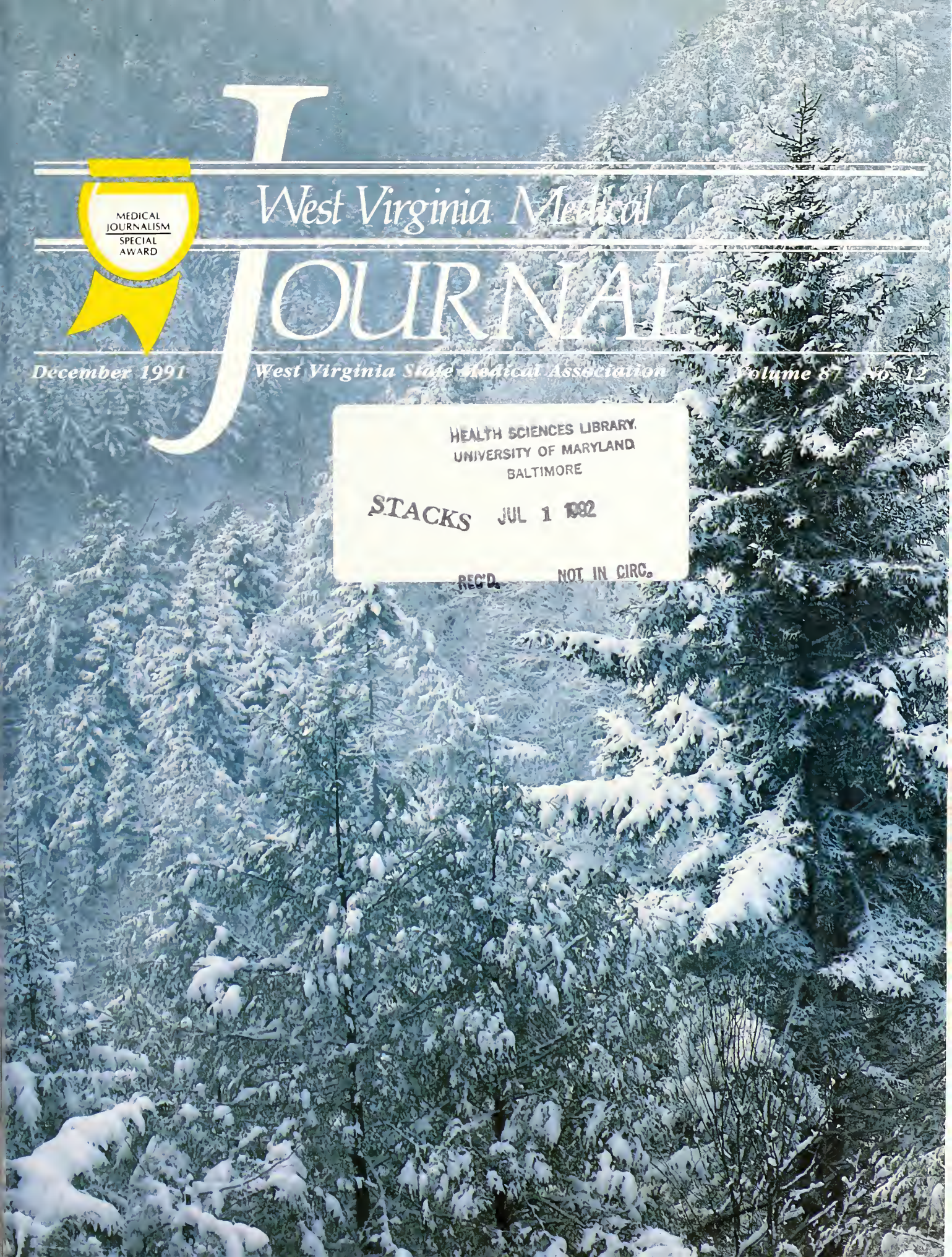

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Front Cover

Snow-covered Cheat Mountain in Pocahontas County makes a picturesque winter scene. Photo courtesy of *David Fattaleh, West Virginia Division of Tourism and Parks.*

Level of reading difficulty in educational pamphlets and informed consent documents for cancer patients

STEVEN J. JUBELIRER, M.D.
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Abstract

Nationwide samplings and data from the 1980 census suggest that a high proportion of patients cared for are functionally illiterate. Since educational materials and consent forms are often given to patients with little regard for their ability to read them, this study was designed to analyze the readibility of educational materials and consent forms at the Cancer Center of Southern West Virginia at Charleston Area Medical Center.

Results of the survey showed that although the median education of the 127 patients studied was 10th grade, more than 30 percent could not be expected to read at the 10th grade level. Most tested patient education materials required a reading level of 11th to 14th grade, and cooperative group consent forms required a college-level reading comprehension. If patient-directed written material is to serve its purpose, then outpatient populations should be surveyed and the reading level of written material adjusted accordingly.

Introduction

Written educational and informational materials are an important source of health information for consumers. They are an important and potentially useful means to complement verbal instructions, assure that consent for tests and procedures is informed, and enhance compliance with treatment. However, it is especially challenging for physicians to provide appropriate written information to their patients since they vary in their intellectual and educational levels, in their interest in the subjects presented, and in their reading comprehension.

In certain medical specialities, many of these materials have been found to be written at a level of difficulty above the reading ability of the intended audience. Sixty-one of 74 patient education pamphlets developed by the American College of Obstetricians and Gynecologists (ACOG) Committee on Patient Education were found to be written at a reading difficulty level of 11th grade or higher, a level higher than the literacy level of many women (1). In another study, surgical consent forms from five major hospitals had a reading level judged to be comparable to the reading difficulty of a scientific journal (2).

The purpose of this study was to evaluate the reading level of representative cancer educational pamphlets and informed consent documents and, therefore, assess whether the level of reading difficulty is appropriate for the majority of patients seen in an outpatient oncology clinic.

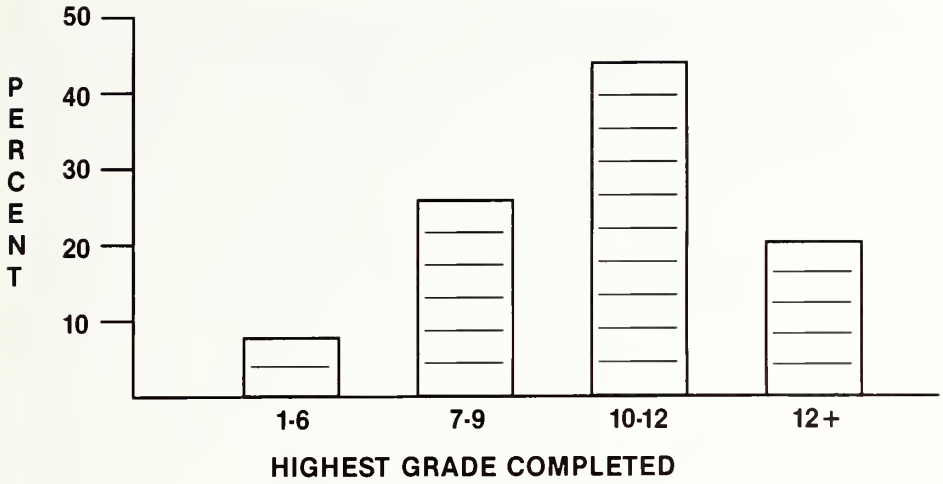
Materials and Methods

A single examiner gathered data from 127 consecutive adult patients at the Cancer Care Center of West Virginia at the Charleston Area Medical Center over a one-month period. Demographic information obtained included age, race, sex, and the highest grade of formal education completed. Patients under the age of 16 are seen at a separate facility and therefore were not represented in the data generated.

The reading level of 60 National Cancer Institute (NCI) or American Cancer Society (ACS) educational pamphlets available in the clinic, and the consent forms of the 20 cooperative group investigational protocols available through the West Virginia Community Clinical Oncology Program was determined using McLaughlin's SMOG test for readability (3). This formula was originally developed by G. Harry McLaughlin in 1969. It will predict the grade-level difficulty of a passage within 1.5 grades in 68 percent of the passages tested (3). Although McLaughlin did not state the meaning of "SMOG," it has since been attributed to mean "simple measure of gobble degook" (4). A SMOG grade level score was computed for each piece of literature by:

a) Dividing the text of interest into three sections (beginning, middle and end) and selecting 10 consecutive sentences in each section;
b) Counting the total number of words with three or more syllables; and
c) Computing the approximate square root (nearest perfect square) of the number of polysyllabic words (including repetitions) and incrementing the square root by a factor of three. For example, 67 polysyllabic words would be rounded to 64, for a square route of eight. Three added to the square root would yield a value of 11. This is the SMOG reading grade level that a reader must have to understand the text fully.

FIGURE 1.



The Fry Readability Formula was also applied to 20 of the cancer education pamphlets and 10 of the informed consent documents (5). In this formula, three 100 word passages are selected and the average number of syllables and average number of sentences per 100 words are plotted on a graph to determine the grade level of the material. The Fry formula is based on a prediction criterion of 50 percent-75 percent comprehension (i.e. if a printed passage received a readability score of 8th grade, individuals reading on an eighth-grade level will read the material with a 50 percent-75 percent accuracy).

Although there are more than 40 different formulas for assessing the degree of difficulty in reading materials (6), the SMOG and Fry formulas were selected for this study for two reasons:

1) They are simpler to use and faster than most readability formulas; and
2) They have been extensively used to analyze the reading difficulty of other health-oriented literature (7,8,9,10).

Since formal testing of reading comprehension is too complex and time-consuming to be performed in a busy oncology clinic, the educational achievement (i.e. the highest grade of formal education obtained) was used as a measure of expected reading level. Reading experts and textbook publishers generally agree that this method overestimates true reading ability by one or two years. This is due to the fact that a textbook must be written at one or two Fry levels below a given grade to be comprehensible to all adults who have completed that grade. In addition, two studies have shown that patients demonstrated word recognition skill levels often much lower than expected by reported years of education (11,12).

Results

The patients surveyed ranged in age from 17 to 84 years. Three were black and 124 were white. There were 77 women and 50 men, and 64 percent of the patients were from Charleston and Kanawha County, with 36 percent from surrounding rural counties.

The levels of formal education of the patients are shown in Figure 1. Eleven (8 percent) had no more than an elementary school education; 3 (24 percent) had not progressed beyond the junior high level; 60 (47 percent) finished some high school (35 percent completed grade 12); and 25 (21 percent) had an education beyond grade 12. The mean educational level of all patients was just above 10th grade.

Fifty-five of the educational pamphlets are written at a reading difficulty level of 10th grade or higher (mean grade: 11; range 8-14). All but one of the informed consent documents (see Table 1) are written at a reading difficulty level of 13th grade or higher (mean SMOG grade level: 13; range: 12-15). Table 3 lists the SMOG grade level of various types of publications (13).

The Fry and SMOG readability formulas were compared in 20 of the cancer education brochures and 10 of the informed consent documents. The 20 brochures had a mean grade level of 9.5 and 11.0 as determined by the Fry and SMOG formulas respectively. The 10 informed consent documents had a mean Fry grade level of 12 and SMOG grade level of 13.

Discussion

The data obtained suggests a serious discrepancy between the literacy levels of a group of patients in a hospital oncology clinic and reading grade level of the information pamphlets and consent forms available to them. Since 55 percent of the U.S. adult population has a reading level below the 10th grade (14), and 40 percent of the above patient sample in this study had completed 10th grade or less of formal education, it seems that many cancer education pamphlets and most informed consent forms are not being understood by a large portion of patients who read them.

The conclusions drawn from this research are somewhat limited by the small sample size and the fact that the sample was not proven to be representative of the oncology outpatient population. However, included patients were entered consecutively over a number of clinic days, and there is no reason to believe the sample was not representative. In addition, reading comprehension was not directly measured, but only estimated by highest grade level of formal education achieved.

Although the SMOG and Fry formulas have been developed to predict the reading grade level required to understand written materials, they bypass the characteristics of the reader. Factors known to influence comprehension such as format, organization, technical accuracy, motivation and interest of the reader and relevance of information to the reader, are not measured by these formulas (7,9,15,16,17). Nevertheless, determining the reading difficulty of written patient-oriented information

TABLE I. READING LEVEL OF INFORMED CONSENT FORMS FROM SELECTED ONCOLOGY COOPERATIVE GROUP INVESTIGATIONAL PROTOCOLS, USING THE SMOG FORMULA

PROTOCOL #	TITLE	SMOG GRADE LEVEL
NSABP - B-17	A Clinical Trial to Evaluate the Natural History and Treatment of Patients with Non-Invasive Intraductal Adenocarcinoma of the Breast	15
NSABP - B-18	A "Unified" Trial to Compare Short Intensive Pre-Operative Systemic Adriamycin and Cyclophosphamide Therapy with Similar Therapy Administered in Conventional Post-Operative Fashion	13
NSABP - B-19	A Clinical Trial to Compare Sequential Methotrexate, 5-Fluorouracil with Conventional CMF in Primary Breast Cancer	13
NSABP - B-20	A Clinical Trial to Determine the Worth of Chemotherapy and Tamoxifen Over Tamoxifen Alone in the Management of Patients with Primary Invasive Breast Cancer, Negative Axillary Nodes, and Estrogen Receptor-Positive Tumors	13
NSABP - B-22	A Clinical Trial to Evaluate the Effect of Dose Intensification and Increased Cumulative Dose of Postoperative Adriamycin-Cyclophosphamide Therapy on the Disease-Free Survival and Survival of Patients with Primary Breast Cancer and Positive Axilary Nodes	13
NSABP - C-04	A Clinical Trial to Assess the Relative Efficacy of 5-FU + Leucovorin, 5-FU + Levamisole in Patients with Dukes B_2 and C Carcinoma of the Colon	13
EST 1683	National Intergroup Protocol for Intermediate Thickness Melanomas 1.0 to 4.0 mm. Evaluation of Optimal Surgical Margins (2 vs 4 cm) Around Primary Melanoma and Evaluation of Elective Regional Lymph Node Dissection	13
EST 1788	Adjuvant Trial of Soft Tissue Sarcoma	14
EST 1887	A Phase III Trial of Cystectomy Alone	13
INT 0080	Versus Neoadjuvant M-VAC and Cystectomy in Patients with Locally Advanced Bladder Cancer	
EST 3487	A Phase III Comparison of CHOP Versus M-BACOD Versus PRO-MACE-CYTABOM Versus MACOP-B in Patients with Intermediate, or High-Grade Non-Hodgkin's Lymphoma	13
EST 3588	Phase III Study of Cisplatin plus Etoposide Combined with Standard Fractionation Thoracic Radiotherapy Versus Cisplatin Plus Etoposide Combined with Multiple Daily Fractionated Thoracic Radiotherapy for Limited Stage Small Cell Lung Cancer	12
EST 3885	Phase III Study of Intraperitoneal Cis-platinum/Intravenous Cyclophosphamide Versus Cis-platinum (Intravenous)/ Intravenous Cyclophosphamide in Patients with Non-measurable Optimal Disease Stage III Ovarian Cancer	14
EST 3886	Randomized Phase III Evaluation of Hormonal Therapy Versus Observation in Patients with Stage D, Adenocarcinoma of the Prostate Following Pelvic Lymphadenectomy and Radical Prostatectomy	13
EST 4588	Phase III Study of Radiation Therapy Alone or in Combination with Chemotherapy for Patients with Non-small Cell Lung Cancer	13
NSABP - R-02	A Clinical Trial to Compare Adjuvant Methyl CCNU, Vincristine, 5-FU (MOF) with and without Radiation to Adjuvant Leucovorin and 5-FU (LV-5-FU) with and without Radiation in Patients with Duke's B and C Carcinoma of the Rectum	13
EST 9486	The Treatment of Multiple Myeloma Utilizing VBMCP Chemotherapy with or without Intensification or Alpha-2-Interferon	14
EST 1490	A Randomized Placebo-Controlled Phase III Study of Granulocyte - Macrophage Colony Stimulating Factor (RHU-GM-CSF) in Adult Patients (>55-70 Years) with Acute Non-Lymphocytic Leukemia	13
EST 2886	Phase III Study of Interferon Alfa (Wellferon R) as Adjuvant Treatment for Resectable Renal Cell Carcinoma	12
EST 1390	Phase II Trial of Interferon Alpha and Chemotherapy in Locally Recurrent or Metastatic Head and Neck Cancer	15
EST 9288	Combined Modality Treatment for Resectable Metastatic Colorectal Carcinoma to the Liver: Surgical Resection of Hepatic Metastases in Combination with Continuous Infusion Chemotherapy	14

TABLE II: THE SMOG READING GRADE LEVEL OF VARIOUS PUBLICATIONS

SMOG READING GRADE LEVEL	TYPICAL MAGAZINE
6-7	Comics
8	Pulp Fiction
9-10	Reader's Digest
11-13	Atlantic Monthly
14-16	Academic magazines
17+	Scientific professional magazines

is important to predict whether the target population will understand the material.

To a certain extent, the nature of the information that must be communicated in health education materials, biases the literature toward a higher reading level requirement. Medical and technical terminology cannot be entirely eliminated, particularly in materials that attempt to present comprehensive information on a topic. An important step in the process of developing cancer education literature is to determine what terms need careful determination for that target population, as well as to explore use of simpler substitute terms wherever possible. For example, the term *uterus* is not understood by many women, while the simpler term *womb* is more understandable. It is important that medical terms be defined early in the text and not left to be defined at the end of the publication.

Additional measures to reduce problems associated with readability in cancer education pamphlets and consent forms include:

1) Using shorter sentences;
2) Using shorter words;
3) Having consent forms read and critiqued by patients as well as fellow professionals, particularly since most institutional review boards are usually made up of persons whose educational level and reading abilities are not representative of potential signers of the forms, and
4) Analyzing proposed educational pamphlets and consent forms with the SMOG or fry formulas or both.

By understanding factors that influence comprehension, health care professionals can modify available materials or develop their own. Patients benefit because they understand their management better, and physicians benefit because their efficiency will be enhanced and their patients' compliance should increase.

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Medical Grand Rounds

West Virginia University Health Sciences Center

Edited by Irma H. Ullrich, M.D., Professor of Medicine

Coronary angioplasty and surgery for coronary artery disease

Discussants:
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Associate Professor of Medicine, Section of Cardiology
RONALD C. HILL, M.D.
Associate Professor of Surgery, Section of Cardiothoracic Surgery

Abstract

Heart disease remains the most common cause of morbidity and mortality in the United States. During the 1970s until the early 1980s, patients with angina pectoris refractory to medical therapy could only consider bypass surgery to relieve their symptoms. Beginning in the early 1980s, coronary balloon angioplasty became an alternative to bypass surgery in those with single vessel coronary artery disease and failure to medical therapy. In the mid-1980s, patients with multi-vessel coronary artery disease also were seen to benefit from balloon angioplasty. Now in the 1990s, balloon angioplasty's success is being compared to coronary bypass with prospective randomized trials. While balloon angioplasty has become relatively easy to perform due to advances in balloon, wire, and guiding catheter technology, many new interventional devices such as atherectomy and laser, are now available. The explosion in technology reflects our inability to prevent atherosclerotic disease and also reveals that while we can improve a patient's lifestyle and in some situations improve mortality rate, atherosclerotic disease remains a disease for which we have no cure.

Percutaneous transluminal coronary angioplasty

Non-bypass mechanical intervention for atherosclerotic coronary artery disease (CAD) has experienced rapid growth in numbers and complexity since the first balloon coronary angioplasty in 1977 by Andreas Gruentzig (1). Since the popularization of this technique over the last 10 years, in excess of 400,000 balloon angioplasties were performed in 1990.

The "take-off" year for balloon angioplasty was 1985, especially in terms of complex CAD with a significant increase in multi-vessel balloon angioplasty. Since 1988, the number of balloon angioplasties has exceeded the number of coronary artery bypass (CABG) procedures even though the number of bypass procedures continues to increase yearly. Rather than competing with coronary bypass surgery, coronary angioplasty is complementary and demonstrates the improved relief of anginal symptoms compared to medical therapy alone.

The increase in the numbers of balloon angioplasty procedures as well as the success of percutaneous transluminal coronary angioplasty (PTCA) reflects better balloon technology, i.e. low profile, improved trackability, high pressure limits, longer length, etc., as well as better trained and experienced operators.

With careful patient selection and high volume operators, failed PTCA is less frequent. Attention to predictors (2,3,4) of acute closure such as: lesion length, angled segments, $>45^0$ branch stenosis, presence of thrombosis, and presence of multi-vessel lesions significantly improves an individual patient's risk and ultimate outcome.

The American Heart Association and the American College of Cardiology have recommended a system to classify coronary lesions according to the likelihood of initial success which is defined as a >20 percent reduction in diameter narrowing with the final diameter stenosis <50 percent (5,6). The Type A lesion is the best suited for PTCA and the Type C lesion the least.

Type A lesions represent high success (>85 percent) and low risk balloon angioplasty lesions. They are discrete (<10 mm. in length), concentric, easily accessible, without angled segments, smooth, without calcification, not totally occluded, non-osteal, without major side branches, and without thrombus.

Type B lesions represent moderate success lesions (60 percent-85 percent) with moderate risk of abrupt vessel closure. They are tubular (10 mm. - 20 mm. long), eccentric, with moderate tortuosity of proximal segments, with moderate angles ($>45^0$ but $<90^0$), with irregular contours, moderately to heavily calcified, totally occluded for less than 3 months, may have osteal location, may have bifurcating lesions requiring double guide wires, and include lesions with some thrombus present.

Type C lesions represent low success (<60 percent) lesions with high risk of abrupt vessel closure. They are diffuse (>20 mm. in length), excessively tortuous proximally, extremely angled ($>90^0$), totally occluded for longer than 3 months, with the inability to protect major side branches and degenerated vein grafts with friable lesions.

Proximal right coronary artery disease and advanced age (>70 years) both predict increased risk of abrupt closure with PTCA. The strategy of "attacking" a "culprit" lesion in the presence of multi-vessel lesions also improves a patient's risk.

The value of PTCA lies in, as previously alluded to, the procedure's ability to relieve anginal symptoms. The Veterans Administration ACME (7) was a randomized trial of PTCA vs.

medical therapy for single vessel coronary artery disease. This study showed PTCA to be markedly superior to medical therapy. While this study showed no improvement in short-term survival, Emory University data for multi-vessel disease PTCA showed a 95 percent freedom from cardiac death at 5 years (8).

There are several randomized trials of PTCA vs. CABG presently ongoing. One is the Emory Angioplasty Surgery Trial (EAST) which completed patient entry in April 1990. Another is the Bypass Angioplasty Revascularization Investigation (BARI). Patient randomization will be completed this summer and both trials are sponsored by the NHLBI. These trials should help define those patients who will be better treated by either PTCA or CABG.

While present balloon technology has allowed a rapid expansion of PTCA procedures, an intra-coronary balloon procedure is not an ideal intervention. The atherosclerotic plaque is cracked with intimal disruption from the more normal arterial wall. This is associated with a 4 percent-8 percent abrupt closure (2,9,10) rate and a 30 percent-40 percent) re-stenosis rate (2,3). These problems have lead to a search for better technology. The ideal device, according to Dr. King of Emory, would remove the atherosclerotic plaque, leave behind a rheologically friendly surface, produce a lumen the same size as the diseased artery, and leave no damage to the remaining media and elastic tissue (4).

No such "ideal" tool is available, but new technology is now in use in an attempt to conquer these problems. These devices include atherectomy devices, both directional-excisional (DCA) and rotational-abrasive (Rotablater). There are lasers (Excimer) to vaporize plaques and stents to support lumens compromised by abrupt closure.

The Simpson Directional Atherectomy (DCA) device has been approved for coronary use for several months and its major indication is for osteal lesions. The DCA leaves a larger lumen and is associated with a lower re-stenosis rate compared to balloon angioplasty for proximal left anterior descending lesions (11). Eccentric and friable lesions such as those found in bypass grafts are well treated with this device. The disadvantages of this device are its need for large guiding catheters, e.g. 9.5 F for the right coronary artery and 11 F for the left coronary artery; and is not suited for long lesions, e.g. >10 mm., or small lumens, i.e. <2.5 mm. In addition, angles and bends are poorly traversed by this device.

The Rotablater has been approved for peripheral vascular intervention and approval for intra-coronary intervention is anticipated in a few months. It works well for short (<10 mm.) "hard" lesions in smaller and more tortuous vessels (12). However, unlike the Simpson DCA device which has a "nosecone" to collect debris, the myocardium distal to the site of rotational abrasive atherectomy must absorb the debris which is generated. There is a finite limit of the myocardium to "digest" the debris after which myocardial ischemia and/or injury can occur.

The DCA device uses a cutting rotational blade to excise the atheroma and displace it into the device's nosecone. The Rotablater uses a diamond-tipped head which spins at 180,000 RPM to abrade the atheroma. Both are placed over guide wires.

The Excimer laser (soon to be approved for intracoronary use) is also an over-the-wire system. It uses laser energy to vaporize atheroma. The vapor generated and a resultant shock wave can result in intimal injury and dissection. The Excimer laser is very useful for osteal lesions and "long" lesions (13). The high cost of this laser (approximately $250,000) is its main disadvantage.

Stents are useful to maintain lumen patency following acute occlusive dissection (14). Stents can "bridge" a patient to CABG under more stable and elective conditions, or it may serve as a therapeutic end in those lesions that appear underdilated with a balloon alone (14).

The disadvantage of these devices is they are very thrombogenic (15). Therefore, intense anticoagulation with aspirin, dextran, warfarin and heparin is required until endothelialization occurs. Acute thrombosis occasionally occurs in spite of these measures. Additionally, groin hematomas become significant with frequent need for blood transfusions.

Randomized trials are now underway to assess re-stenosis prevention with DCA vs. PTCA, e.g. coronary angioplasty vs. excisional atherectomy trial (CAVEAT), and with stents vs. PTCA alone.

Other technologies being investigated for intracoronary use include intracoronary ultrasound, fluorescent spectroscopy, Raman spectroscopy, angioscopy, and Doppler ultrasound. These devices are better able to differentiate the normal arterial lumen from the diseased portion. They also better assess the results of intracoronary intervention compared to angiography.

Balloon angioplasty still remains a relatively simple tool for mechanical intervention for CAD. It will continue to account for 85 percent-90 percent of intracoronary interventional procedures because newer technology remains limited in its application and ease of use. All of these intracoronary interventions result in significant improvement in the quality of life in terms of control of anginal symptoms. It remains to be determined if mortality can be improved, and, the economic cost of these procedures will come under increased scrutiny due to the widening application and increased frequency of use.

Surgery for coronary artery disease

There are approximately 500,000 coronary revascularizations per year in the United States. Although left ventricular (LV) dysfunction has previously been felt to be a contraindication for bypass surgery, it is now considered to be an indication. In most series, patients with ejection fractions greater than 20 percent are considered operative candidates. Three studies looking at surgery versus medical treatment, the VA study, the European study, and the CASS study, showed that high-risk subjects benefited more

from the surgery than medical treatment (16,17,18,19,20,21). The VA trial continued to show that left main coronary artery disease was a surgical modality. In the CASS registry, asymptomatic left main disease was felt to be a surgical disease.

Three-vessel disease

Again in the CASS study, three-vessel disease with severe ischemia or angina irrespective of LV function benefited more from surgery. The dispute arose when there was three-vessel disease and mild-to-minimal angina or ischemia.

At seven years, and subsequently at 10 and 11 years, the CASS study showed that three-vessel disease with normal LV function showed no benefit between surgery over medical treatment as far as survival was concerned. However, over a period of time, there was a large crossover from the medical to the surgical group. It was felt that mild stable angina or mild ischemia on stress test with normal LV function in three-vessel disease could be initially treated medically with very careful follow-up (16,17,18,19,20,21). These patients may go to surgery if the stress test becomes more positive or if they develop more symptoms. The opposite continued to be true that those with mild angina or ischemia and abnormal LV function benefited more from surgery at seven years and this was affirmed at follow-up 10 and 11 years later.

Two-vessel disease

The European study showed that two-vessel disease with proximal left anterior descending artery disease was a surgical disease and patients with two-vessel disease and severe angina who had abnormal LV function should undergo bypass grafting.

Thus, patients with severe angina, abnormal LV function and two or three-vessel disease, should undergo revascularization. No procedure prolonged survival in patients with mild ischemia and normal LV function. The intermediate group was those with severe ischemia and normal LV function or mild ischemia and abnormal LV function. The evidence showed that individuals with three-vessel disease should undergo bypass grafting and those with two-vessel disease probably should undergo medical treatment with close follow-up (16,17,18,19,20,21).

Myocardial infarction

Acute myocardial infarction continues to be a dilemma for the surgeon. Clinical situations where surgery may be of benefit include:

1. Failed thrombolysis or angioplasty
2. Within six hours of infarction
3. Post infarction angina
4. Occluded vessel at angioplasty
5. Occluded vessel at catheterization
6. Cardiogenic shock in patients who are intra-aortic balloon dependent and can be revascularized
7. Ventricular septal defect
8. Papillary muscle dysfunction

When the ejection fraction is greater than 50 percent, the short-term mortality is low, but when the ejection fraction is equal to or less than 50 percent, mortality increases significantly. The problem with revascularization of acute myocardial infarctions within six hours is not that the hospital mortality may be low, but that there may actually be no improvment in LV function. Patients presenting with an acute myocardial infarction secondary to single vessel obstruction should probably undergo angioplasty first. If this is unsuccessful, then one should consider revascularization (22).

The TIMI 2 study has shown that coronary artery bypass grafting within 24 hours of a failed angioplasty (i.e. emergency) had a hospital mortality as high as 15 percent (23). It also has demonstrated that half of the patients undergoing CABG within 24 hours of a failed angioplasty had single-vessel disease, and only 22 percent of these patients received an internal mammary artery as their conduit of choice (23). If doing an angioplasty for an acute infarction, one should only dilate the culprit infarct-related artery at that time. Patients presenting with a Q-wave infarct, who have a positive stress test at one week, otherwise stable, and an ejection fraction of 30 percent, may have their surgery delayed for three to four weeks. Those who have a non-Q wave infarct, can probably undergo surgery in this setting in approximately two weeks with reasonable mortalities. In most series, if the ejection fraction is less than 18 percent, one would consider transplant or an assist device (22).

Surgery for cardiogenic shock

Cardiogenic shock is usually the direct consequence of myocardial ischemia or mechanical lesions. When cardiogenic shock complicates a myocardial infarction, the mortality may be as high as 85 percent. Patients who are intra-aortic balloon dependent and can be weaned have long-term mortality greater than 70 percent without revascularizations. Thus, if they need to be revascularized, it may be done from one to six weeks following removal of the balloon pump if they are stable. If they cannot be weaned, there is an approximate 50 percent-60 percent operative mortality with early revascularization (22). Many now feel that for cardiogenic shock, the patient should undergo direct primary angioplasty. This has been confirmed by the GISSI-1 trial which showed no difference between the thrombolytic treatment and placebo in cardiogenic shock (24).

In conclusion, the question for the future will not be who needs to be revascularized, but in the high risk patient, what form of revascularization should be done.

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The *West Virginia Medical Journal* will not consider for publication a paper or work that already has been reported in a published paper, or is described in a paper submitted or accepted for publication elsewhere.

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Use double spacing throughout, including (in the following order) title page, abstract, text, acknowledgements, references, tables, and legends for illustrations. Begin each of the following sections on separate pages: title page, abstract, text, acknowledgements, references, individual tables, and legends for illustrations. Number pages consecutively, beginning with the title page. Type the page number in the upper right-hand corner of each page.

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Jane S. Altmeyer

One caring heart

The West Virginia State Medical Association Auxiliary is off to a fantastic year. Beginning with our 1991 post convention board meeting, three goals were set which will have a significant impact this year.

Our **first** goal is to gain over 300 new members in 1992 in order to reach a membership total of 1,000. Members are the essence of our organization. By increasing our membership and encouraging more involvement by our current members, we will see a difference in the impact of the WVSMA Auxiliary.

Our **second** goal is to maintain a positive attitude. Throughout the country, volunteer organizations are experiencing a decline in membership and an increase in apathy. Unfortunately, we are no exception, but fortunately we have set the wheels in motion to focus on the positive aspects of West Virginia medicine. We will concentrate our efforts on wellness initiatives, public support of mandatory seat belt usage legislation, and health projects sponsored by the various auxiliaries.

The positive side of the WVSMAA will also be measured by attendance at our board meetings. Our projections are to attain a representative body of at least two-thirds of county auxiliary chapters at each meeting. The 17 auxiliaries are Cabell County, Central West Virginia, Eastern Panhandle, Fayette County, Greenbrier Valley, Harrison County, Kanawha County, Logan County, Marion County, Mercer County, Monongalia County, Ohio County, Parkersburg Academy, Preston County, Raleigh County, Tug Valley and Tygarts Valley. In addition, we have close to 20 members that belong to WVSMAA as members-at-large because there are no organized chapters in their areas.

Our **third** goal is to restructure the board meetings so they are adaptable to the changing needs of today's auxiliary members. The 1992 spring board meeting will be changed from a one and a half day session to a concise, one-day meeting. At the conclusion of the spring meeting, an evaluation will be made on the new format. Following that meeting, plans will begin on redesigning the annual meeting, which is held in August.

To a greater degree, the WVSMAA will focus inward this year to include the development of job descriptions of the various committees and officers and to clearly establish policy positions. After research and networking with other state medical auxiliaries, the findings will carefully be reviewed by our Bylaws and Handbook Committee. The plans include publishing job descriptions and policies in our roster.

Four statewide goals to be accomplished this year have also been established by the WVSMAA. One of these plans has already been carried out with the activities held for Health Awareness Week, November 17-23. I am very pleased with the wide range of health topics that were presented by the county medical societies and their auxiliaries during this special week. Our other statewide goals involve organizing and strengthening the Auxiliary Phone Bank for legislative alerts and other pertinent messages, conducting a voter registration drive, as well as a candidate forum preceding the 1992 elections.

On the national front, the AMAA is re-examining their long range objectives. In particular, national will explore the identity of the organization, including a possible name change from the word "auxiliary" to one more fitting of today's federation of medicine.

The theme for my year in office is "One caring heart is all it takes to make a difference." As I travel through the state, I come into contact with many individuals in our federation who possess these caring hearts and I see firsthand the difference we have made.

—Janie Altmeyer
President, WVSMA Auxiliary

Overgrowth

We once objected to the categorization of medical care as an "industry." We just didn't understand because we just didn't know enough about industries. We didn't realize how, in industries, so many people feed off of one product. We understand a little more clearly now. An industry is a lot like a tree.

We understand too, that just like the steel or coal industries, if the industry is too large and too overgrown, it needs to be cut back -- sort of like pruning a tree. There have been painful cutbacks in the coal and steel industries and many others besides, but somehow the country has survived.

The trick for medicine is to trim back the medical industry without diminishing medical care. It all seems simple enough. There's a lot of feather-bedding out there in the medical care industry. It's time we started pruning our industry.

We could start with lopping off the insurance branch. Everyone could just bring cash to the office. That way, too, we could certainly do away with the precertification overgrowth and even the PRO because when someone is paying cash up front, they are not going to be too anxious for any of the frills.

Let's not forget those parasites feeding off our medical industry tree -- plantiff attorneys. Let's cut deeply there with tort reform shears. Presto! No more defensive medicine.

It's not likely that we will ever get back to that era, but there was a time, not too many years ago, when the only office person you were likely to see at the doctor's office was the lady who took your name and told you when it was your turn to be seen. In most cases, that lady was the doctor's wife.

Things were certainly cheap (cost effective) in those days before the price went up (uncontrolled medical care cost inflation).

Now, it's one of several secretaries who takes your name, your third party payor information, social security number and all the other personal information needed to get the bill sent out properly. That same individual will explain to you or point out a sign detailing the payment policy of the office. The other employees are busy typing out coded claims forms for dispatch to various insurers, coding, posting payments, or folding dunning letters. When you finally get through to the doctor, there is likely to be a nurse or two and maybe even a technician of some kind in the vicinity.

Medical care has been burdened with the support of numerous other individuals and their families.

That's just the start of it. All those forms sent to an insurer are opened by someone, presumably read by someone, and the information is somehow inserted into a main frame computer, which then diligently searches for a reason the bill should be paid by someone else or not paid at all if the procedure is a non-covered benefit, or precertification requirements were not met, or maybe PRO review was not passed.

Medical care sags under the weight of additional insurance clerks, supervisors, executives and their families.

There are a lot of sucker branches on our tree contributing little or nothing to anyone's health. A good pruning never hurt any tree, but we are somehow unconvinced that the public will like the new shape of our medical care tree.

—SDW

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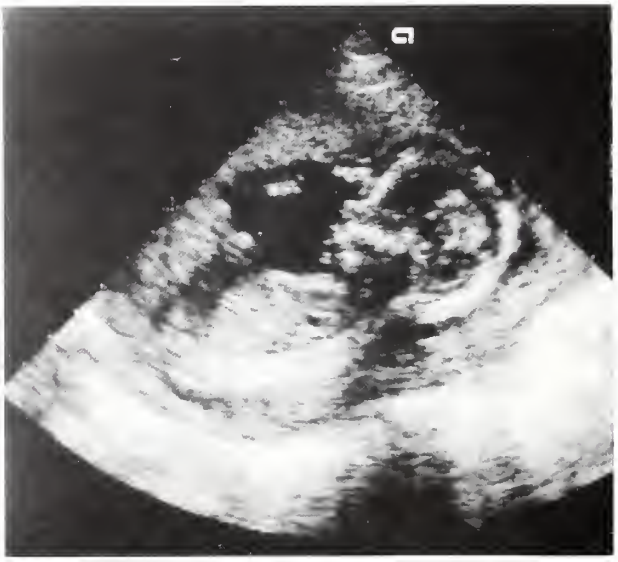

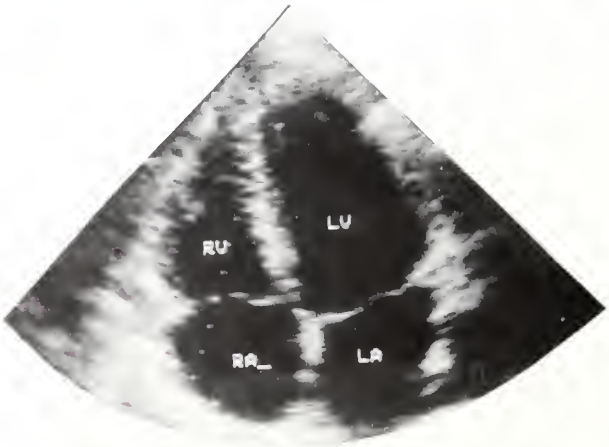

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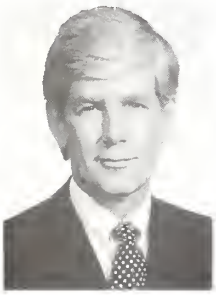
- Micro Surgery
- Update on Forensic Medicine
- Hepatitis-C

Potpourri panel also complete

Dr. DeVries among speakers for Mid-Winter public session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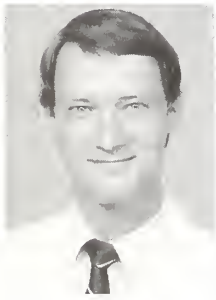
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World renown cardiothoracic surgeon **William DeVries, M.D.,** director of the Artificial Heart Program at Humana Hospital Audubon in Louisville, will be one of the featured speakers for "Medical Ethics: Who Lives, Who Dies, Who Decides," this year's Public Session at the West Virginia State Medical Association's 1992 Mid-Winter Clinical Conference, January 24-26, at the Radisson Hotel in Huntington. In addition, panelists have also been finalized for the Fourth Scientific Session at the conference which will highlight a wide variety of subjects such as ethical dilemmas due to obstetrical advances, advice for expert court witnesses, microsurgery and new testing for Hepatitis-C.

Scheduled to begin at 7 p.m. on Friday, January 24, the Public Session will start with Dr. DeVries addressing "Difficult Decisions in Medical Treatment/Ethical Choices." **Alvin "Woody" Moss, M.D.,** director of the West Virginia University Center for Health Ethics and Law, will then focus on "Better Health for Less Cost: Do We Have the Will to Achieve It?" The third panelist will be **Irene Keeley,** an attorney from Clarksburg, speaking on "The Use of Advance Directives in Making Health Care Decisions in West Virginia." The panel will conclude with a presentation entitled "Medical Ethics in West Virginia," from **Robert "Chuck" Chambers,** speaker of the West Virginia House of Delegates. This session will be moderated by **Robert Hall,** chairman and professor of the Sociology Department at the College of Graduate Studies in Institute.

Four speakers are also scheduled for the Fourth Scientific Session on Sunday, January 26 at 9 a.m., which will be moderated by **Robert D'Alessandri, M.D.,** dean of the WVU School of Medicine. WVU Associate Professor **Roger Toffle, M.D.,** will begin the panel with "Ethical Dilemmas of the New Reproductive Technologies." Charleston psychiatrist **Ralph Smith Jr., M.D., M.B.A.,** will then present his lecture entitled "Please Take the Stand — Expert Advice for the Occasional Expert Witness in Court." Next, **William Barwick, M.D.,** of Duke University, will speak on "Microsurgery." The final speaker will be **Mabel Stevenson, M.D.,** clinical professor of pathology at Marshall University and assistant executive director of medical affairs at St. Mary's Hospital in Huntington, who will express her views on "Hepatitis-C: What Does the New Testing Tell Us?"

Biographical information about each of these speakers begins below and more details about the meeting are available by contacting Nancie Divvens at 925-0342.

Public session panelists

Dr. DeVries was born in Brooklyn, N.Y., and received his bachelor of science and doctor of medicine degrees from the University of Utah. He did an internship in surgery at Duke University Medical Center in Durham, N.C., where he was also a National Institute of Health scholar in academic surgery and a research fellow in surgery and physiology.

In 1972, Dr. DeVries was named surgical director of the Physicians' Associate Program at Duke and the following year took on more responsibilities as a clinical research associate at the U.S. Veteran's Administration Hospital in Durham. From 1974-78, Dr. DeVries served as the senior assistant resident and then the chief resident in general and cardiothoracic surgery at the school.

Dr. DeVries became an instructor in surgery at Duke in 1978, but left after a year to relocate to Salt Lake City to become an associate professor of surgery at the University of Utah School of Medicine and serve as chief of cardiothoracic service at Salt Lake City Veteran's Administration Medical Center. In 1980, Dr. DeVries was promoted to additional academic roles as chairman of the division of cardiothoracic surgery at the University of Utah and assistant director of surgery for the ICU at the Veteran's Administration Medical Center. The following year, he assumed another position at the university as co-director of the Surgical ICU.

In 1983, Dr. DeVries was promoted to associate professor of surgery at the university, but he resigned the following year so he could move to Louisville to accept his current post as director of the Artificial Heart Program at Humana Hospital Audubon. Since 1988, he has also been on the faculty of the University of Kentucky at Louisville as an assistant clinical professor.

During his career, Dr. DeVries has become known around the world for his achievements in the development and implantation of the artificial heart and received numerous awards. In 1983, he was named the honoree of the American Academy of Achievement, and in 1985 he received an oscar from the World Book of Inventions in Paris.

A noted author, Dr. DeVries has lectured extensively and is very active in professional and community activities. He is a fellow of the American College of Chest Physicians, the American College of Cardiology, the Southeastern Surgical Congress and the American College of Surgeons.

Dr. Moss received a bachelor's degree in social relations at Harvard College in 1971 and then obtained his doctor of medicine degree at the University of Pennsylvania. He did his residency in internal medicine at North Carolina Memorial Hospital in Chapel Hill, N.C., from 1975-78, and then continued his postgraduate studies with a renal fellowship at the University of Colorado Health Sciences Center in Denver.

From 1980-83, Dr. Moss worked as a staff physician at three hospitals in Greensboro, N.C., and was also an assistant clinical professor of medicine at the University of North Carolina School of Medicine in Chapel Hill. In 1983, he relocated to West Virginia to become an assistant professor of medicine in the nephrology section at WVU and medical director of hemodialysis for the Renal Dialysis Unit at WVU Hospitals Inc.

Dr. Moss assumed a new role as medical director of the West Virginia Health Care Cooperative Dialysis Program in 1985. The following year, Dr. Moss was promoted to associate professor of medicine at the WVU Health Sciences Center and became chief of the nephrology section at the WVU School of Medicine, as well as president of the Mountain State Organ Procurement Agency.

Since 1990, in addition to his role as associate professor, Dr. Moss has been serving as director of the Center for Health Ethics and Law at the WVU Health Sciences Center. Last year, he was also named an adjunct associate professor in the department of dental practice management in the WVU School of Dentistry. He presently serves as a consulting physician on the staffs of the Davis Memorial Hospital in Elkins, United Hospital Center and the Louis A. Johnson Veterans Administration Medical Center in Clarksburg, and as a staff physician at WVU.

During the past six years, Dr. Moss has continued his postgraduate training with courses in bioethics at the Kennedy Institute of Ethics at Georgetown University in Washington, D.C., and medical ethics studies at the University of Washington School of Medicine in Seattle. In addition, Dr. Moss was one of only eight physicians in the U.S. chosen to participate in the National Leadership Training Program for Physicians in Clinical Medical Ethics at the University of Chicago Pritizker School of Medicine from 1989-90.

A board certified internist and nephrologist, Dr. Moss is chairman of the Hospital Ethics Committee at WVU Hospital and since 1988, has been the organizer and coordinator of the West Virginia Network of Hospital Ethics Committees.

Irene Keeley received an A.B. degree in history from the College of Notre Dame of Maryland in Baltimore and taught school in Prince George County, Md., for a year before moving to Harrison County, W.Va., to accept a secondary teaching position.

After four years with Harrison County schools, Keeley continued her education at WVU and received an M.A. degree and then her doctor of jurisprudence degree. Following her graduation from law school, Keeley joined the firm of Steptoe and Johnson in Clarksburg, where she had worked as a law clerk while attending WVU.

In her practice, Ms. Keeley specializes in representing hospitals and physicians in the defense of medical and hospital liability claims. An adjunct professor at the WVU College of Law, Keeley is a member of the West Virginia State Bar Special Committee on professionalism. She drafted West Virginia's Medical Power of Attorney Act and serves on the Guardianship Task Force of the West Virginia Department of Health and Human Resources.

In addition to her active role in the West Virginia State Bar, Keeley is a member of the American Bar Association, the West Virginia Law Institute at the WVU College of Law, the Harrison County Bar Association, the Defense Trial Counsel of West Virginia, the Defense Research Institute, the American Association of Hospital Attorneys, the National Health Lawyers Association, the West Virginia Society of Hospital Attorneys and the American Society of Law and Medicine.

Chuck Chambers received a B.A. degree in political science from Marshall University and his doctor of law degree from WVU. After obtaining his doctor of jurisprudence degree in 1978, Chambers was elected to the West Virginia House of Delegates, where he currently serves as speaker.

During his entire career in the House of Delegates, Chambers has been a member of the Judiciary Committee and was appointed chairman in 1985. Other positions he has held in the House include chairman of the Joint Committee on Legislative Rule-Making Review and

vice-chairman of the Select Committee on Redistricting.

An attorney in the Huntington firm of Chambers, Chambers and Heilman, Chambers serves on the Board of Governors of the West Virginia Trial Lawyers and is a member of the Executive Committee of the National Conference of State Legislatures.

Potpourri panelists

Dr. Toffle was born in Bemidji, Minn., and graduated from the University of Minnesota with his doctor of medicine degree in 1974. After receiving his medical degree, Dr. Toffle was a rotating intern for a year, and then a resident in obstetrics and gynecology for three years at the Naval Regional Medical Center in San Diego.

In 1978, Dr. Toffle was given a new station in Naples, Italy, with the department of ob-gyn at the Naval Regional Medical Center, and was named chief the following year. Returning to the U.S. in 1982, Dr. Toffle accepted a teaching position as an instructor in obstetrics and gynecology at the University of Minnesota for two years, where he also studied as a fellow.

Dr. Toffle moved to West Virginia in 1984 to become an assistant professor in obstetrics and gynecology at WVU and in 1987, he was promoted to his current post as associate professor. Throughout his career, Dr. Toffle has remained active with the Navy, and in 1991 was awarded with his second National Defense Medal.

Certified by the National Board of Medical Examiners and the American Board of Obstetrics and Gynecology, Dr. Toffle has been a visiting professor at several medical schools and hospitals, and written book chapters, articles and abstracts.

Dr. Smith is a native of Charleston who received his doctor of medicine degree at Northwestern University in Chicago in 1966. After graduation, he did an internship at Evanston Hospital in Evanston, Ill., and then a residency in general psychiatry and a fellowship in child psychiatry at the University of Cincinnati Medical Center.

Following his residencies, Dr. Smith practiced adult and child psychiatry and coordinated the Alcoholism Clinic of Cincinnati for a year. In 1971, he began working as a staff psychiatrist at the Municipal Court Psychiatric Clinic in Cincinnati and as a teaching fellow in child psychiatry at the University of Cincinnati Medical Center, but left that same year to serve as a major in the U.S. Air Force Medical Corps. He held assignments at Clark Air Force Base in the Philippines, and in Thailand and Taiwan before returning to Charleston and opening his private practice for adult, child and forensic psychiatry.

From 1974-1987, Dr. Smith was the commander of the 130 TAC Clinic for the West Virginia Air National Guard at Yeager Airport in Charleston. In addition, from 1979-81, Dr. Smith was a consultant at the Gallia Meigs Mental Health Center in Gallipolis, Ohio, and from 1981-86, was medical advisor for the Bureau of Hearing and Appeals at the Social Security Administration.

An associate clinical professor in the department of behavioral medicine and psychiatry at Charleston Division of WVU, Dr. Smith is on the active medical staff at the Charleston Area Medical Center and Highland Hospital, where he directs the substance abuse program. Dr. Smith is currently involved with two preceptorships for child psychiatry fellows and second-year residents from the WVU Medical Center to Highland Hospital.

Dr. Barwick is a native of Denver who received his doctor of medicine degree at University of Tennessee College of Medicine in 1971. After completing an internship and a general surgery residency at the University of Tennessee Memorial Research Center and Hospital in Knoxville, Dr. Barwick continued his postgraduate studies with a general surgery residency at the Medical Center of Central Georgia in Macon, and a plastic surgery residency at Duke University Medical Center in Durham.

Currently an assistant professor in the division of plastic and maxiollofacial surgery at Duke, Dr. Barwick is now also a consulting plastic surgeon at the Veterans Adminstration Medical Centers in Durham and Fayetteville, N.C. He is certified by the American Board of Surgery and the American Board of Plastic Surgery.

Dr. Barwick is a co-author of the book "Essentials of Plastic, Maxillofacial and Reconstructive Surgery," and has written extensively for several scientific journals.

Dr. Stevenson is a native of Ireland who attended Queen's University of Belfast for her medical degree and then completed two internships and a clinical pathology residency at hospitals in Belfast. She also did a fellowship in blood coagulation studies at the Baker Institute in Melbourne, Australia, from 1957-58.

In 1958, Dr. Stevenson moved to the U.S. to become the director of the laboratory at Rochester State Hospital in Rochester, Minn. She held this position for three years and then relocated to West Virginia and accepted a position as assistant professor and staff clinical pathologist at the WVU Medical Center, where she was later promoted to associate professor. In 1968, Dr. Stevenson was given the added role of director of the WVU Hospital Blood Bank and took a sabbatical leave in 1974 to serve as a honorary consultant in clinical pathology for the Oxford Area Health Authority in England.

After 13 years at WVU, Dr. Stevenson relocated to Huntington to become director of the Tri-State Red Cross Blood Services, teach at the Marshall University School of Medicine and work as a consulting pathologist at the Veterans Admininstration Hospital. Dr. Stevenson is still a clinical professor of pathology at Marshall and a consulting pathologist at the VA, but has recently assumed a new position as assistant executive director of medical affairs at St. Mary's Hospital, where she is also chairman of the Transfusion Committee.

Active in many associations and organizations, Dr. Stevenson is a board member of the West Virginia Medical Institute, chairman of the Huntington Area Hemophilia Association and State Hemophilia Program, and area chairman of the American Association of Blood Banks Inspection and Accreditation Program.

Healthy West Virginia Coalition activates new plan

The Healthy West Virginia Coalition unveiled their plan entitled "Moving Toward a State of Wellness" at the Fifth Annual Governor's Conference on Worksite Wellness in Charleston on October 24. Donning a WVSMA T-shirt especially created for the event, John Holloway, M.D., one of WVSMA's representatives on the coalition, jogged with the governor and others from the Governor's Mansion to the Marriott to receive the plan.

The coalition is composed of members from the West Virginia State Medical Association (Drs. Holloway and Warren Point), the West Virginia Health Education Council, the West Virginia Bureau of Public Health, the West Virginia State Health Committee, and the Wellness Council of West Virginia. These five organizations, when considered collectively, represent five of the major channels for health promotion.

The coalition stated that a "State of Wellness" is achievable and absolutely necessary to the future of West Virginia, and made the following recommendations:

1) The West Virginia Year 2000 Health Goals be considered as worthy objectives that will provide the focus and framework necessary for all involved parties to work together to address health care problems in the state.
2) The Healthy West Virginia Coalition be designated to facilitate the planning, communication and recommendation of resource allocation to assist communities in taking effective action.
3) Community-based efforts be encouraged and supported. Local initiatives are most successful because they are planned, organized and implemented by those who understand local problems, and can most benefit from their solutions.
4) Resources of the state be allocated toward prevention programs for our citizens, especially those at higher risk. This investment should be considered as a long-term commitment to alter the cultural dynamics influencing healthy behaviors.
5) Additional resources be identified and developed to support health promotion/ disease prevention initiatives.

Governor Gaston Caperton (third from left) and Dr. John Holloway of Wheeling (front right) jogged with some of the other members of the Healthy West Virginia Coalition from the Governor's Mansion to the Charleston Marriott for the presentation of the coalition's new state wellness plan.

The Wellness Council of West Virginia, who sponsored the conference, presented "Well Workplace" awards to organizations and businesses who had put programs in effect and helped their employees improve their lifestyles. The highest honor, the Wellness Workplace gold award, was presented to Charleston Area Medical Center, who became the first company in the nation to earn this award.

WVTS annual meeting to be held at Silver Creek

The West Virginia Thoracic Society (WVTS) will hold its annual scientific session January 10-12, at Silver Creek Resort in Pocahontas County. The session will include presentations and discussions on pulmonary topics and provide time to relax and ski.

Featured speakers include Robert McAfree, M.D., of the University of Oklahoma; Daniel L. Herr, M.D., of George Washington University; and physicians from throughout West Virginia. The sessions are geared toward the practicing physician who provides care for patients with chest illnesses of all types.

Attendees are eligible for Category 1 CME credits and special resort weekend packages. For information and registration, contact the American Lung Association of West Virginia at 342-6600.

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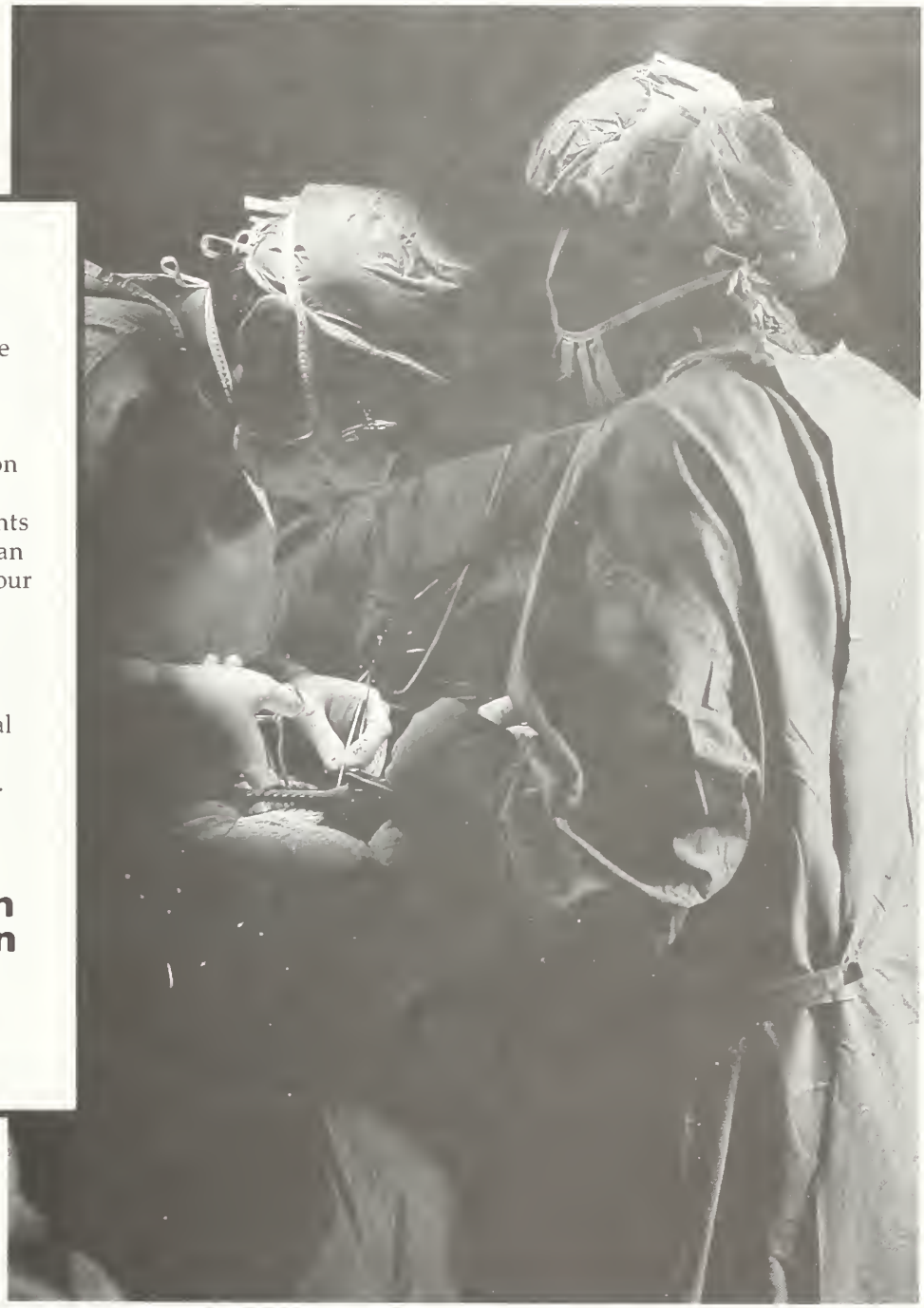

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Continuing Education

Listed on this page are some of the upcoming CME programs which will be held in the state.

The programs this month were compiled by: Robin Rector, coordinator of CME for Charleston Area Medical Center; Marie Chute, secretary of the Ohio Valley Medical Center CME Department; and Thelma Wilson, education coordinator of the Raleigh County Medical Society.

Further details about these CME activities may be obtained by calling Rector at 348-9580; Chute at 234-8310; and Wilson at 255-6341. Other state and national meetings are listed in the Medical Meetings Section of the *Journal*.

If you would like to have the CME programs offered by your institution or association for physicians published in the *Journal*, please contact Nancy Hill, managing editor, at 925-0342.

Ohio Valley Medical Center - Wheeling

Jan. 15 - "Nosocomial Pneumonia," Matthew Levison, M.D., professor and chief of the infectious diseases division, Medical College of Pennsylvania, 8 a.m.

Raleigh County Medical Society-Beckley

Dec. 17 - "Antihypertensive Therapy: Impact on CVD Risk Factors," VA Medical Center, noon, Black Knight Country Club, 6:30 p.m.

Outreach Programs

Key to Sponsors

★ *WVU Health Sciences Center, Morgantown*

☐ *CAMC/WVU Health Sciences Center, Charleston*

Man ☐ Man Appalachian Regional Hospital, Dec. 17, 7 p.m., STBA*

Logan ☐ Logan General Hospital, Jan. 17, 11:30 a.m. "GI Bleeding/Pancreatitis," STBA*

Ripley ☐ Jackson General Hospital, Jan. 10, noon, "Medical Research," Mary Francis Blanton, MS, ED

Spencer ☐ Roane General Hospital, Dec. 17, 12:30 p.m., Stroke Rehabilitation," Peter Americo, MS, Donna Busch, RN

**STBA—Speaker to be announced*

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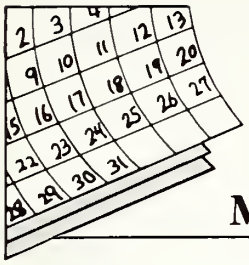


Medical Meetings

January

15-18—Contact Lens Association of Ophthalmologists, Las Vegas.
16-18—American Academy of Pain Medicine, Scottsdale, Ariz.
18—Tardive Dyskinesia, Ohio State University, Columbus.
19-25—18th Southern Clinical Neurological Society Meeting, Islamorada, Fla.
24-25—Transfusion Medicine 1991, sponsored by American Association of Blood Banks, held in both Arlington, Va. and Los Angeles.
24-26—West Virginia State Medical Association's Mid-Winter Clinical Conference, Huntington.
29-31—Southern Society for Pediatric Research, New Orleans.
31-February 2—1st Conference on Imaging in the Health Sciences, University of Texas, Houston.

February

10-12—Aging: The Quality of Life, Christopher Columbus Medical Sciences Committee of the National Institute of Health, Washington, D.C.
10-12—Beyond Deficiency: New Views on the Function and Health Benefits of Vitamins, New York Academy of Sciences, Arlington, Va.
12-16—National Update on Allergy and Clinical Immunology Conference, sponsored by National Jewish Center for Immunology and Respiratory Medicine, Keystone, Colo.
14-15—Infectious Diseases 1992: Current Problems, Ohio State University, Columbus.
14-16—American Academy of Cosmetic Surgery, Los Angeles.
17-19—Cardiopulmonary Rehabilitation Symposium: Status '92, Orlando.
20-25—American Academy of Orthopaedic Surgeons, Washington, D.C.
23-28—Sixth Annual Innovations in the Diagnosis and Treatment of Gastrointestinal Disorders, sponsored by Georgetown University Medical Center, Snowmass, Colo.

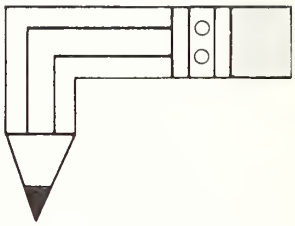
March

5-7—Strong Children for a Strong America: National Choices, Community Strategies, Children's Defense Fund Annual National Conference, Atlanta.

For More Information . . .

Contact the Journal for additional information about most of the above meetings. Call (304) 925-0342.

Poetry Corner



It Never Rests

Oh, seemingly, way out beyond
Where sky and water make their blend,
There is no movement --
But illusion makes that bond.

And although sailing ships becalm,
Their hulls keep cleaving through the deep
As the rolling currents North or South
Their measured meters keep.

As the shore illusion's gone,
The roily surf, the striking waves,
The eddies and the undertow
Surly are, we must confess,
The splashing, crashing, booming proof
Of the ocean's restlessness.

R. L. Smith, M.D.

Please address your submissions for Poetry Corner to: Stephen D. Ward, M.D., Editor, West Virginia Medical Journal, Box 4106, Charleston, WV 25364.

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Pediatric Surgery	**Neurosurgery**

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You may serve near your home, at times convenient for you, or at Army medical facilities in the United States and abroad. There are also opportunities to attend conferences and participate in special training programs, such as the Advanced Trauma Life Support Course.

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WEST VIRGINIA UNIVERSITY HEALTH SCIENCES CENTER

Compiled from material furnished by the West Virginia University Health Sciences Center News Service, Morgantown.

Chairman named for Microbiology/ Immunology

Dr. Barnett

John B. Barnett, Ph.D., has been named to chair the Department of Microbiology and Immunology in the West Virginia University School of Medicine, effective January 1.

"Dr. Barnett brings to WVU a new perspective on the protection of mothers and babies from the long-term effects of prenatal exposure to chemicals," said Robert D'Alessandri, M.D., dean of the School of Medicine. "This research will fit well with our efforts to improve the overall health of West Virginia children. By studying these substances in the laboratory and using research models, we are helping protect future generations from injury."

Dr. Barnett is currently associate dean for research at the University of Arkansas in Little Rock, where he has been on the faculty since 1975. He holds a doctorate degree in microbiology from the University of Louisville, along with B.S. and M.S. degrees from Montana State University. He completed an NIH post-doctoral fellowship at the University of Tennessee.

Lions clubs dedicate eye research unit, screening van

Representatives of many of West Virginia's 239 Lions Clubs gathered Sunday, November 3, at the WVU Health Sciences Center to dedicate the new Lions Clinical Eye Research Unit.

This new treatment and research facility is a $70,000 addition to the WVU Eye Center and will provide space and state-of-the-art equipment for patient care and a variety of clinical eye research projects.

A grant from Lions Clubs International Foundation was matched with funds raised by the 7,000 members of West Virginia Lions Clubs to establish the unit.

A pre-school vision screening and early intervention program, free screening programs for glaucoma and diabetic retinopathy, projects using electrophysiology to detect eye disease, an evaluation of normal and abnormal tear flow, a study of dyslexia, and an evaluation of contact lenses currently used after corneal surgery, are just a few of the projects currently under way or in the planning stages at the facility. The unit also features expanded facilities for the Eye Center's Low Vision and Visual Rehabilitation Service.

The Mobile Eye Screening Unit, a specially equipped vehicle that will make possible a free, statewide screening program, was also unveiled at the dedication ceremony. It is a joint project of the West Virginia Lions Sight Conservation Foundation and the West Virginia Eye Institute.

Bladder cancer research featured in journal article

Dr. Lamm

Donald L. Lamm, M.D., professor and chairman of the WVU Department of Urology, is the principal investigator of a clinical article published in the October 24 issue of the New England Journal of Medicine.

The article compares two types of chemical therapy used in a nationwide, 46-institution study focusing on the treatment of certain bladder cancers. The more effective treatment proved to be with the drug bacillus Calmette-Guerin, or BCA.

Dr. Lamm has researched BCA extensively, and was instrumental in securing FDA approval in May 1990 for the use of BCA in treating bladder cancer.

Surgeons perform first jejunal graft

Abdolkarim Sohrabi, associate professor of surgery at the WVU School of Medicine and attending surgeon at the Louis A. Johnson VA Medical Center in Clarksburg, led a team of surgeons in the state's first free jejunal graft for repair of the cervical esophagus.

Harold E. Holt, 66, was the first patient in the state to successfully undergo this operation which repaired his esophagus with a free graft from his small intestine.

The operation was performed at the VA Medical Center by Drs. James Bland, an ENT surgeon, and John Pickens, an ENT resident, who removed the cancer from Holt's neck. Drs. Sohrabi, David Fogarty, a plastic and reconstructive surgeon, and David Genecov, a WVU surgery resident, harvested the graft and transplanted it to the neck.

NY Times Magazine features Dr. Fogarty

David C. Fogarty, M.D., a Morgantown plastic surgeon and clinical associate professor in the WVU School of Medicine, is among the medical volunteers featured in an article about Interplast which appeared in the October 20 issue of the New York Times Magazine.

Dr. Fogarty donates a month or more each year to Interplast, and has made many of the trips. He recently served on the team that made the first post-war visit to Vietnam to do reconstructive surgery on children with war injuries and birth defects.

Your CPA: Making Taxes Less Taxing

Question: The evening news just called, saying they'd like to see your tax return. Your first impulse is to call:

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- ☐ b. Your "significant other."
- ☐ c. Your guru.
- ☐ d. Your mommy.
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AIR FORCE

MU School Of Medicine News

Compiled from material furnished by the Office of University Relations, Marshall University.

Students volunteer at area clinics

Medical student volunteers are now being matched with underserved clinics as part of the new Volunteer Clinical Service Program recently created by the Marshall University School of Medicine.

"This program gives first-year students some elementary clinical experience and sets the tone for them to provide medical and health care to West Virginians," Renee Kogan, academic affairs coordinator said. "It was created at the request of the students and is not a part of the medical school curriculum," she added.

First-year medical students may spend up to two evenings per month at one of five area participating clinics — the St. Andrews Episcopal Church Clinic, the Wayne Health Service, Carl Johnson Medical Center, Grant Medical Center, and the Ft. Gay Primary Health Center.

"We have 14 students who are volunteering their time in such areas as interviewing patients and taking blood pressures, pulses and temperatures," Ms. Kogan said. "Considering their academic workload, we think it's especially admirable that they want to commit part of their limited free time to help others."

Students participating in the program are John Adams, Shelley Bailey, Michael Clark, Gary Cremeans, Ramona Davidson, Amy Hamilton, Chaundra Hensley, Bruce Hines, Jacqueline Mayo, Dawn McFarland, Joe Shanklin, Rodney Sirk, Jack Trainor and Katherine Williams.

New program offered for gifted students

Marshall's Department of Family and Community Health was one of six schools nationwide to be authorized to offer a new program which encourages outstanding medical students to remain in the state to practice.

The program, which starts July 1, will allow selected students to combine their fourth year of medical school with the first year of a family practice residency.

"This program gives outstanding students an added incentive to stay at Marshall for their residencies, and that increases the chances they will ultimately practice in West Virginia," said Dr. Robert Walker, chairman of family and community health. "Preference will be given to students who show a strong commitment to practicing in a small town or rural area," he added.

Participants will continue to pay tuition during their fourth year, but also will receive payment for their services as residents.

Dr. Walker said the University of Kentucky has had good success with its accelerated residency program in family practice and has shown the program to be educationally sound.

The traditional fourth-year program of electives will continue to be available for students in all fields, including family practice.

Sports medicine institute to open

To help area athletes and fitness enthusiasts maximize their potential while avoiding injuries, a Sports Medicine and Fitness Institute is being created at Marshall University.

The institute is a joint effort of the School of Medicine and Marshall's Division of Health, Physical Education and Recreation and the Department of Athletics. Support for the institute will be obtained from grants, contracts and fees for services.

Athletes will be able to improve their performance by using high-speed cameras, videotape and computers. Pre-exercise testing and movement analysis will also be featured at the institute to help sports enthusiasts avoid injuries and illness.

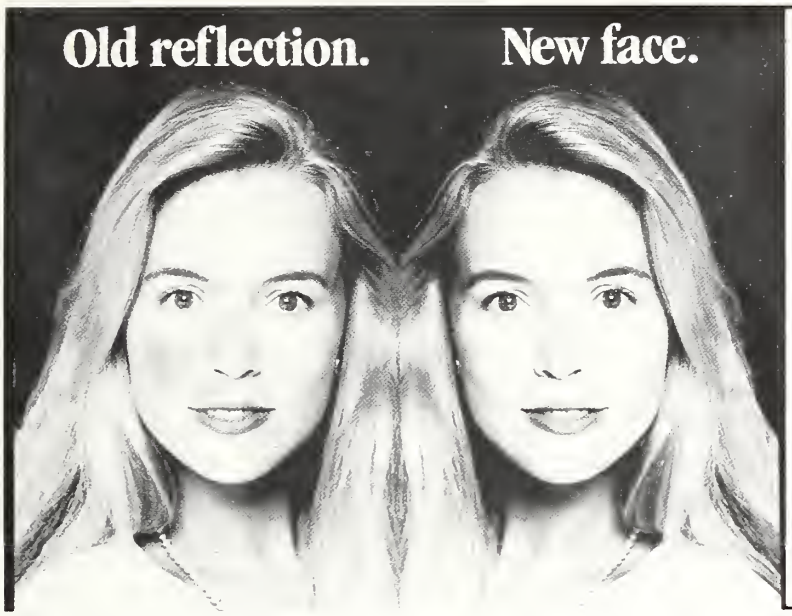
"There is no other program like this in the state; in fact, there are not many places that offer this type of special program," W. Donald Williams, Ph.D., chairman of Marshall's Department of Health, Physical Education and Recreation said. "Our main emphasis is promoting fitness as preventive medicine, but we will also be equipped to offer cardiac rehabilitation services, as well as provide guidance to coaches and players in organized sports."

Dr. Williams noted that the region and state have a great need for outreach associated with preventable diseases, such as heart disease, obesity and diabetes.

Walker, Schneider receive promotions

Charles H. McKown Jr., has appointed Dr. Robert B. Walker as acting associate dean for clinical affairs, and Mr. James J. Schneider has been promoted to associate dean for finance and administration.

"Given Marshall's enhanced opportunities to expand the kinds of rural service already being done so successfully here, I could not find stronger leadership or greater expertise than that which already exists under Bob Walker," Dr. McKown said. "In addition, Mr. Schneider has worked with financing of higher education for 17 years and has an unparalleled knowledge of funding for higher education in West Virginia."



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Physicians' Recognition Awards

We wish to congratulate the following WVSMA members who recently received Physicians' Recognition Awards from the AMA for voluntarily completing 150 credit hours of continuing medical education during the past three years:

Cabell
J. Alan Cochrane
Roy Alvin Edwards
Robert Allen Kayser
James Robert Morris
Dennis Stephen O'Connor
Joseph B. Touma
William E. Triest

Central West Virginia
James D. Brown

Eastern Panhandle
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Raleigh
Lamberto Cendana Maramba
Anindya Kumar Sen

Tug Valley
Nilkanth B. Purohit

Tygarts Valley
Donald C. Carter
Samuel K. Roberts

Obituaries

Rodgers Harshbarger, M.D.

Dr. Rodgers W. Harshbarger, 74, of St. Albans, died February 8 in Thomas Memorial Hospital after a short illness.

Dr. Harshbarger graduated in 1939 from The Citadel in Charleston, S.C., with a B.S. degree, and then received his medical degree from the University of Virginia. He was an Army veteran of WWII and a lifelong resident of St. Albans, where he was a family practitioner for 38 years before retiring in 1984.

During his career, Dr. Harshbarger served as medical consultant for the Kanawha County Board of Education and was team physician at St. Albans High School, as well as city health officer for St. Albans. He was a former president and vice-president of the medical staff at Thomas Memorial Hospital.

Dr. Harshbarger was a member of the American Academy of Family Physicians and had been a member of the WVSMA since 1948. In addition, he was also a member of First Presbyterian Church of St. Albans, Washington Masonic Lodge 58 of St. Albans, Charleston Scottish Rite Bodies and Beni Kedem Shrine.

Survivors include his wife, Alice S. Lynch Harshbarger; daughters, Nancy H. Joneth of Raleigh, N.C., Sarah H. Noble and Mary Bruce Kessler, both of St. Albans; son, Dr. R. W. "Mike" Harshbarger of St. Albans; stepdaughter, Joanne Hunt of Greenville, S.C.; stepsons, Dr. W. Allen Lynch of Greenville, and John S. Lynch of Belton, S.C.; brother, Dr. Ward Harshbarger Jr. of Dunbar; sisters, Dorothy B. of St. Albans; Elizabeth Hurt of Roanoke, Va.; and 15 grandchildren.

William Earl McIvain, M.D.

Dr. William Earl McIvain, M.D., 86, of Huntington, died at his home on September 5.

Born in Glen Easton, Dr. McIvain received a B.S. degree from Lincoln Memorial University in Harrogate, Tenn., and then obtained his doctor of medicine degree from the University of Louisville.

During his career, Dr. McIvain practice medicine in Sutton, Moundsville and Huntington. He was a member of the Marshall County Medical Society and had been a member of the WVSMA since 1938. He served in the U.S. Navy from 1942-46.

Survivors include his wife, Thelma L. McIvain; and his sons William and David of Huntington.

Isidro G. Zarsadias Jr.

Dr. Isidro G. Zarsadias Jr., 53, of Beckley, died July 8 in a Beckley hospital, following a short illness.

A native of the Philippines, Dr. Zarsadias received his doctor of medicine degree from the University of Santo Tomas in Manila. He did an internship at Mercy-Douglass Hospital in Philadelphia and completed residencies at St. John Hospital in Detroit and St. Elizabeth Hospital in Youngstown, Ohio.

Dr. Zarsadias was a physician anesthesiologist in private practice at the Beckley Appalachian Regional Hospital. He was a member of the Raleigh County Medical Society, the American Medical Association, the American Society of Anesthesiologists, the American Society of Regional Anesthesia, the West Virginia State Anesthesiologist Association, the Philippine Medical Association, Knights of Columbus, Black Knight Country Club and St. Francis de Sales Catholic Church.

Survivors include his wife, Lita Gopez Zarsadias; a son, Isidore T. Zarsadias, at home; two daughters, Andrea M. Zarsadias and Jenny M. Zarsadias, both of Beckley; two brothers, Romy Zarsadias, M.D., and Eddie Zarsadias, both of the Philippines, and three sisters, Teresita Balmaceda and Marlene Zarsadias, both of the Philippines, and Lolita Hofilena of Bellevue, Wash.

County Societies

McDowell

Dr. A. Mohiuddin, chief of cardiology at the VA Medical Center in Beckley, spoke on "Hypertension in the 90s," at the October meeting which was sponsored by Roergi.

Following this CME session, Dr. Robert Pulliam, president-elect of the WVSMA, discussed medical problems in West Virginia and the importance of a strong WVSMA. He urged all physicians attending to be members of the county, as well as WVSMA and AMA.

Under new business, a motion was passed to accept Dr. Cecilia B. Bella into membership. In addition, a letter of thanks from the Hospice Care of Mercer County for the society's $350 contribution was presented, and members voted to donate $600 to maternal child services at Welch Emergency Hospital.

At their November meeting, Dr. Siva Prasad, an internist from Welch, presented the program "Update on Calcium Channel Blockers."

Dr. Herland briefly discussed items of interest from the recent WVSMA council meeting and stressed the importance of all county members joining the WVSMA, AMA and WESPAC.

In other new business, members decided not to make donations to L.I.F.E. and the local sheltered workshop, which funds had been given to last year. A financial report was also presented.

The meeting was sponsored by Sandoz.

Monongalia

Mountainview Regional Rehabilitation Hospital sponsored the society's November meeting and the hospital's medical director was the speaker for the evening.

Council met immediately before the meeting and approved supporting the postage expenses of the auxiliary, postponed approval of a $200 gift to the Ronald McDonald House and approved the meeting location for the December meeting.

The following physicians were presented for membership via first reading: Drs. Robert C. Valenzuela, Samuel J. Congello, Daniel S. Frame, Debra J. Paulson, Lee B. Smith, F. Kristin Crosby, Susan L. Weber, Russell F. DeVore III, Thomas G. Pait, Michael V. Osetinsky, Jacqueline P. Benziger, Lynn M. Broadman, Robert E. Johnstone, Daniel H. Stewart, Loan K. Nguyen, Mark K. Wax, John V. Linberg, Charles D. Mayron and David M. Grossman.

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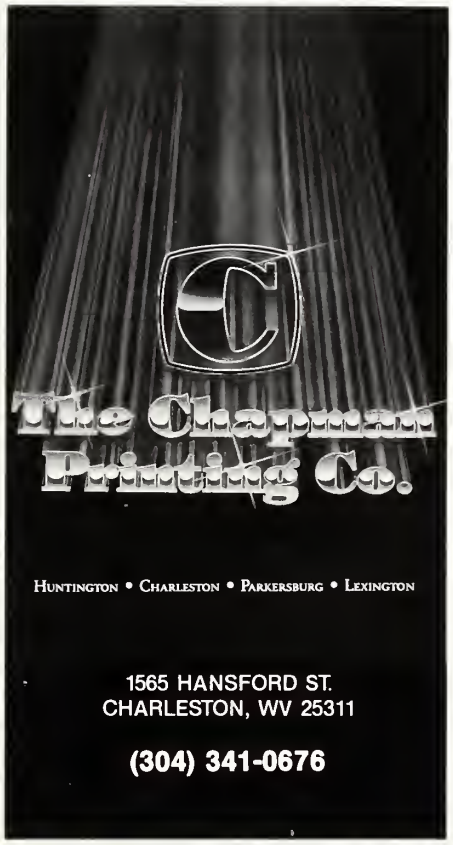

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Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digitoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°,2°,3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

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